*September* **Medical Economics**



* What's Being Done About Emergency Calls • Page 55

# AT LAST! EFFECTIVE RELIEF IN BRONCHIAL ASTHMA

## ——"*inconspicuous side effects*" [1]

Prompt, complete relief in bronchial asthma and associated conditions . . yet "causes very little central nervous stimulation and produces little or no pressor action."[1]

85%–90% effective relief in over 1400 patients during an exacting 8-year clinical study.

Increased vital capacity . . . better feeling of well-being . . . essentially free from undesirable side actions.

## *Its name is* NETHAPHYL®

***For liquid dosage . . . Syrup Nethaprin.®*** Pleasant tasting. Nethaphyl's effective relief, enhanced by Decapryn's long-lasting antihistaminic action in seasonal and other allergies. *Each 5cc contains: Nethamine® 25 mg., Theophylline (U.S.P.) 50 mg., Decapryn® Succinate 6 mg.*

Each capsule contains: Nethamine® Hydrochloride 50 mg., Butaphyllamine® 0.12 Gm., and phenobarbital 15 mg. Also available in half-strength.

MERRELL 1828

...CINCINNATI U. S. A.

1–Hansel, F. K.: Ann. Allergy, 5:397, 1947.

# Medical Economics

* * * *September 1949* * * *



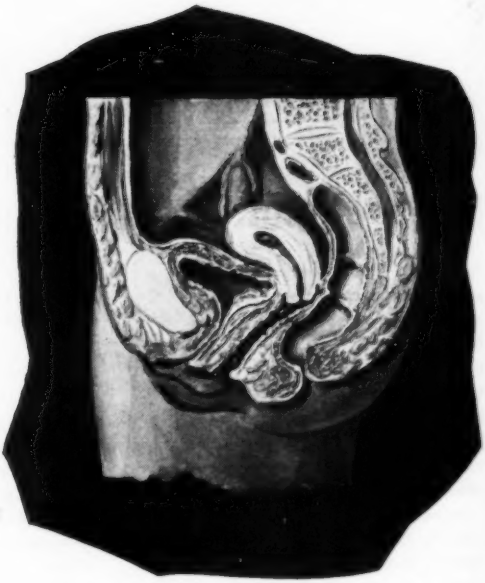
[ CONTINUED ON FOLLOWING PAGE ]

## Contents [*Continued*]






Copyright 1949, Medical Economics, Inc., Rutherford, N.J. 25 cents a copy, $3 a year (Canada and foreign, $3.50). Circulation 138,000 physicians and residents ☆ PICTURE CREDITS: Cover, New York Telephone Company; 45, Pix; 51, Post-Dispatch–Black Star; 57, Pix; 65, Paul Parker; 67, 68, 69, J. Conner Howell; 91, World Wide.



# Check Menstrual Flooding

Considerable irregularity in flow may mark the onset of menstruation at puberty. Menorrhagia, with or without dysmenorrhea, may be most troublesome. In these cases, the excessive bleeding is usually purely functional in character—an organic lesion may be conspicuously absent. This excessive functional bleeding may occur later in life, too.

**Anti-Menorrhagic Factor Armour**

has proven effective in checking such functional hemorrhage—and appears to be quite free from side effects. Best time to start therapy is about two weeks prior to expected onset of menstruation.

Available in soft gelatin capsules (glanules) in boxes of 25, 50 and 100.

Dosage:

Two or three glanules three times daily. For very severe cases patient may be confined to bed during bleeding and dosage upped as high as 8 glanules t.i.d.

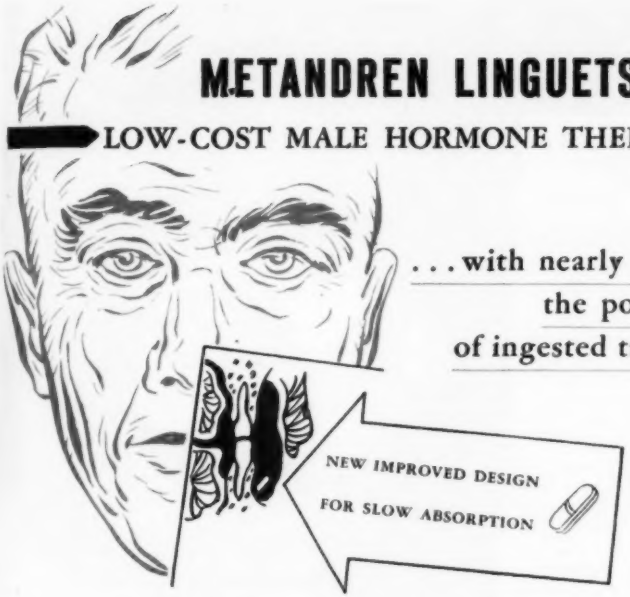
**Have confidence in the preparation you prescribe—specify "Armour"**

**ARMOUR** *Laboratories*

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

# METANDREN LINGUETS

## LOW-COST MALE HORMONE THERAPY




**. . . with nearly twice the potency of ingested tablets**

Metandren Linguets contain methyltestosterone for sublingual or buccal administration.

The superiority of Metandren Linguets over other androgens by this route may be partly attributed to the fact that only methyltestosterone is effective orally. In contrast, when free testosterone or testosterone propionate is given sublingually, that portion unavoidably swallowed is almost completely destroyed.

Metandren Linguets of methyltestosterone are the "most economical and also efficient way of administering testosterone," according to Lisser.[1] Tyler finds that 140 mg. of methyltestosterone weekly in the form of Linguets is equivalent to an ingested dosage of approximately 210 mg., or to an injected dosage of 75 mg. of testosterone propionate.[2]

**PERANDREN**
is the pioneer brand of testosterone propionate, the most potent injectable androgen.

Adult maintenance dosage is from one to three 5-mg. Linguets daily. Most children need only one-half to one 5-mg. Linguet daily. Literature on request.

1. Lisser, H.: Calif. & West. Med., 64: 177, 1946
2. Tyler, E. T.: J.A.M.A., 139: 9, Feb., 1949.

METANDREN LINGUETS, 5 mg. (white), scored; 10 mg. (yellow), scored – in bottles of 30, 100 and 500.

**Ciba** PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY



2/848M

## *Memo from the Publisher*

• A local physician blew into our editorial offices some months ago under a fine head of steam. "What do you mean," he demanded of our awe-struck receptionist, "by printing articles that favor things like compulsory health insurance and osteopathy? And how about these articles criticizing AMA policies, sometimes even individual doctors? Whose side are you on, anyway?"

It's just possible that our receptionist, whom we didn't hire for her agility in public debate, was unable to cope with the situation. We have a hunch that our irate visitor got away with his safety valve still untripped. If so, we consider it one of the most-missed opportunities of the season, for there's actually no question about what our editorial policy is.

MEDICAL ECONOMICS is against state medicine. It is against unqualified practitioners. It is for organized medicine. It is for the individual physician.

So far, no surprises.

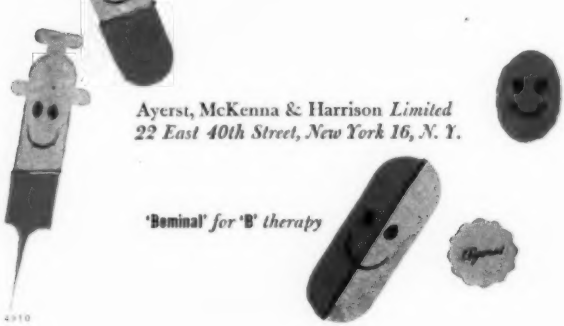
It does occasionally surprise some doctors, however, to learn that MEDICAL ECONOMICS is independently owned and published. Specifically, that means its editorial policy is independent of both its advertisers and the AMA. No publication worth its salt would fail to take advantage of that posi-

# 'Beminal'

## For versatile "B" therapy

The **'Beminal'** family provides a choice of five distinctive forms and potencies for the effective treatment of vitamin **'B'** deficiencies. Each is designed to fill a particular need.

1. **'Beminal'** fortified with Iron, Liver and Folic Acid Capsule No. 821 is suggested for the treatment of iron deficiency anemias, certain macrocytic anemias and as adjunctive therapy in pernicious anemia.
2. **'Beminal'** with Iron and Liver Capsule No. 816 is recommended for the treatment of the various types of iron deficiency, occurring either as frank hypochromic microcytic anemia or as the less pronounced anemia of nutritional origin.
3. **'Beminal'** Forte with Vitamin C Capsule No. 817 is suggested when there is severe depletion of the patient's nutritional stores due to either prolonged dietary inadequacy or nutritive failure as a result of organic disease.
4. **'Beminal'** Forte Injectable (Dried) No. 495 provides, when reconstituted, a high concentration of important vitamin B factors for intensive therapy.
5. **'Beminal'** Tablets No. 815 may be of value if the vitamin B complex deficiency is mild or subclinical.



Ayerst, McKenna & Harrison *Limited*
*22 East 40th Street, New York 16, N. Y.*

**'Beminal'** *for* **'B'** *therapy*

tion by seizing every chance for unbiased appraisal and evaluation and by reporting both sides of controversial questions.

This vantage point seems all the more worth protecting when one thinks about the other medical periodicals. The Journal AMA, for example, could scarcely print both the good and the bad about AMA actions. The state medical society publications and the official specialty journals are similarly limited in what they can say. Nor could an organ of a pharmaceutical house be expected to point resolutely to imperfections in the present system of medical care. The way we look at it, MEDICAL ECONOMICS' job is to help the doctor, both individually and collectively. And helping him isn't always accomplished by tossing bouquets in his direction.

Not all physicians see eye to eye with us on what we publish. So we're glad to give space to those who hold divergent views. Minorities ought to be heard, and they often are in these pages.

We see no point, however, in trying to be all things to all people. Since no one will agree with everything you say, you may just as well say what you think is right—and let it go at that. There is considerable satisfaction in knowing that you have not tried to take two sides at once, thus taking neither.

As for our friend with the skyrocketing blood pressure, if he did not, as we suspect, get the answer he should have gotten from our receptionist, this is it.

—LANSING CHAPMAN

# "Results with Chlorophyll Therapy in 40 Cases of Dermatoses"

**Excerpts from a clinical paper by W. D. Langley, M. D., and W. S. Morgan, M. D., published in The Pennsylvania Medical Journal, 51:44, 1947. This clinical investigation was conducted in the Guthrie Clinic and Robert Packer Hospital, Sayre, Pa.**

*The following synopsis provides physicians a convenient review of the clinical experience of Drs. Langley and Morgan with Chloresium and chlorophyll therapy in the treatment of acute and chronic dermatoses. It quotes their reasons for undertaking the investigation . . . describes the effects of the treatment . . . and summarizes the final results. This report is one of an extensive series of published papers on Chloresium chlorophyll therapy; reprints are available on request.*

***Why investigation was undertaken***

"Following the recent experimental work on water-soluble chlorophyll proving it to be a tissue stimulant which resulted in the suggestion that this drug might be found of value in the treatment of osteomyelitis, burns, and chronic ulcers, it was thought worth while to employ this substance in a series of such cases in an attempt to corroborate clinically the experimental findings. It was while this series† was in progress that we first became aware of the value of water-soluble chlorophyll* in the treatment of dermatoses . . .

"Chlorophyll (Chloresium) was used more or less in desperation when other measures had failed to relieve the subjective symptoms and objective manifestations of several cases of dermatoses of varied type. We knew from our own previous experience and from the literature that chlorophyll was bland in its effect on the skin. We did not anticipate in any measure, however, the degree of beneficial effect produced by chlorophyll . . . in these problems.

***Selection of cases***

"During a period of six months, from February to July, 1946, we treated 40 dermatologic cases, the majority of which had proved highly resistant to all previous treatment.

***Objective results***

"The objective response seen over the involved areas proved to be no less dramatic than the palliation of symptoms. In many of the acute cases, areas which were highly erythematous, swollen, and weeping before application of water-soluble chlorophyll ointment were found to be greatly improved within ten to twelve hours. The absence of oozing after this period of time was most impressive.

"In no patient in this series of dermatologic problems treated with water-soluble chlorophyll has there been any evidence of toxicity or allergic reaction."

†The favorable findings from this study were presented in a report "Treatment of Chronic Ulcers with Chlorophyll," in the Am. J. Surgery, April, 1948).

*The water-soluble chlorophyll ointment used in this study was supplied in generous amounts by Rystan Company, Inc., Mt. Vernon, N. Y. It is marketed under the trade name "Chloresium" (Solution [Plain], Ointment).

**SUMMARY TABLE**

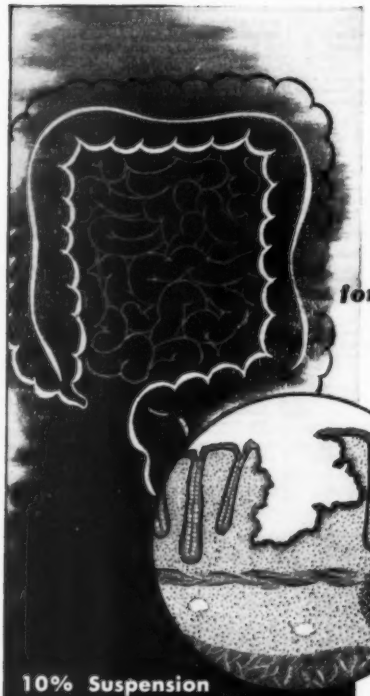
| Diagnosis | No. of Cases | Duration | Previous Treatment | Results from Water-Soluble Chlorophyll Ointment | Statistics and Healing Time |
|---|---|---|---|---|---|
| Contact dermatitis | 8 | Two weeks to eighteen months | Cold boric acid and starch wet dressings; calamine lotions | Relief of itching in all cases; progressive objective improvement; decreased weeping, erythema, edema in acute cases; in chronic type, there was softening of skin and loss of lichenification; removal of crusts | All cases clinically cured: 5 within 10 days, 2 within 2 weeks, 1 within 1 month |
| Stasis dermatitis | 13 | One to eighteen months | Cold boric acid and starch wet dressings; penicillin ointment and bland ointments | Relief of itching and burning in all cases; progressive objective improvements | 12 cases clinically cured: 6 within 10 days, 5 within 3 weeks, 1 within 6 weeks. No objective improvement in 1 case |
| Neurodermatitis | 5 | Three to eighteen months | Cold boric acid and starch wet dressings; x-rays, ultraviolet radiations, and bland ointments | Relief of itching and burning in all cases; diminished erythema, weeping, edema, crusting | All cases showed sustained improvement; 3 cases clinically cured within 2 weeks; 2 cases showed much improvement |
| Seborrheic dermatitis | 3 | Two weeks to one year | Cold wet dressings; penicillin ointment (one case, no previous treatment) | Relief of itching; diminished erythema, edema, weeping, crusting | All cases clinically cured within 2 weeks; 1 case within 2 days |
| Exfoliative dermatitis | 2 | Twelve to eighteen months | Zinc oxide; penicillin ointment; cold wet dressings | Diminished erythema, edema, weeping, scaling, crusting | Both cases clinically cured: 1 case within 2 weeks |
| Infantile eczema | 2 | One to three months | Boric acid ointment and penicillin ointment | Relief of itching; diminished erythema, weeping, crusting | Both cases clinically cured: 1 case within 1 week |
| Sycosis vulgaris | 3 | Two weeks to eight years | Penicillin ointment; x-rays | Relief of itching; diminished erythema, weeping, crusting | 2 cases improved; 1 showed no objective improvement |
| Pyogenic fungus | 1 | Six months | Local applications of unknown type | Good | Healed in 7 days |
| Nummular eczema | 1 | Six months | Local applications | Poor | None |
| Psoriasis | 1 | Twelve years | Numerous local applications | Good symptomatic relief | No effect on lesions in 30 days |
| Moniliasis of vulva | 1 | Three years | X-ray therapy; estrogens; antipruritic application | Relief of itching and burning; was dramatic in 48 hours | Almost complete healing in 2½ mos. |

## CONCLUSIONS

*"Of 40 cases treated with water-soluble chlorophyll (Chloresium), all experienced relief of itching and burning. Thirty-six cases or 90 per cent showed decided improvement objectively. Four or 10 per cent were not improved.*

*"Of the 36 cases showing response to treatment with chlorophyll, 32 or 88.8 per cent have been completely relieved of the present attack. Four continue to improve.*

*"Of the 40 cases, 31 or 77.5 per cent had been active for one month or longer. Nine cases varied in duration from one to three weeks."*



# NOW

## for *Chronic Ulcerative Colitis*

Here is Nisulfazole, after eight years of laboratory work and clinical trial. Its arena, chronic, non-specific ulcerative proctitis and colitis, is limited but the need is serious.

Nisulfazole is unique among sulfonamides. In its structure it carries a nitro radical on the benzene nucleus, but that is not so remarkable. The significant thing is this: Nisulfazole as administered acts against the malady only —not against the patient!

Furnished in a 10% suspension for easy administration directly into the colon, the drug does not significantly enter the patient's circulation; symptoms of systemic toxicity virtually do not occur.

**10% Suspension of**

**Nisulfazole®**

Brand of PARANITROSULFATHIAZOLE

**Supplied in bottles of: 296 cc. (10 fl. oz.) and 2.78 liters (1 gal.)**

*Detailed information to physicians on request.*

BREON

George A. Breon & Company

KANSAS CITY, MISSOURI

RENSSELAER, N. Y.
ATLANTA
SAN FRANCISCO

*minimal side effects*
*smallest effective dose*
*highest therapeutic index*


The clinically effective dosage of **Chlor-*Trimeton*** is far less than that of any other antihistaminic drug in clinical use today CHLOR-TRIMETON* Maleate is administered in doses of but *4 mg. or less,* instead of the customary 25 to 100 mg. doses of other antihistaminics.

## *The uniquely low dosage of* Chlor-*Trimeton* Maleate

is indicative of its increased antihistaminic activity. Excellent control of hay fever symptoms has been obtained with 2 to 4 mg. CHLOR-TRIMETON three or four times daily. Highly effective relief of symptoms is obtained in many other allergic manifestations, such as urticaria, vasomotor rhinitis, angioneurotic edema and drug reactions, including those due to penicillin. Symptomatic control is prompt and sustained; relief is obtained in one-half to one hour and lasts for four to six hours. A major advantage of CHLOR-TRIMETON therapy is the *greatly decreased incidence of side actions, particularly drowsiness.*

*CHLOR-TRIMETON trade-mark of Schering Corporation

PACKAGING:
**Chlor-*Trimeton***
Maleate (brand of chlorprophenpyridamine maleate) Tablets: 4 mg., scored, yellow, in bottles of 100 and 1000.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

Chlor-Trimeton

SCHERING

# emotional equilibrium for the geriatric patient

Thousands of doctors know that BENZEBAR* allays the mental depression, apprehension and nervousness so frequently found in the elderly patient. 'Benzebar' is S.K.F.'s logical combination of Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.) and phenobarbital. It provides the unique improvement of mood of 'Benzedrine' Sulfate and the calming, soothing influence of phenobarbital. These two established agents work together to restore the elderly person's zest for life and living, to quiet his nervousness and, at the same time, to keep him from overdoing.

*Smith, Kline & French Laboratories, Philadelphia*

## Benzebar for the depressed and nervous patient

*'Benzedrine' and 'Benzebar' T.M. Reg. U.S. Pat. Off.

# *Panorama*

Britain having bumper crop of illegitimate births, reports Mass-Observation, non-profit research group. At least 64 per cent of children born to women under 20 are conceived out of wedlock . . . United Medical Service, New York, threatens to replace Michigan Medical Service as nation's largest Blue Shield plan. Each has over a million subscribers, with Michigan leading by only a few thousand.

Austrian Medical Association warns high school students not to study medicine, cites 1,500 Austrian M.D.'s already jobless . . . New bill before Congress permits shipment of live scorpions through the U.S. mails—provided they're for use in medical research . . . As promotion stunt, Los Angeles Daily News offers $1,000 polio insurance policy for $1 . . . Mrs. Kate Newman of South Milford, Ind., is daughter, wife, widow, sister, grandmother, niece, first cousin, and second cousin of doctors.

Kissing doesn't spread germs, says Illinois Health Department. Smooch is "pleasant greeting and a boon to the mental health of mankind" . . . Physician's role in civil disaster is dramatized in new AMA-Becton, Dickinson movie, "They Also Serve," now making rounds of county and state medical societies . . . British Medical Association asks bobbies to help M.D.'s make better time in driving through heavy traffic . . .Oakland, Calif., man accidentally killed himself while trimming toenails. He fell on scissors, punctured his chest.

Retired General Jonathan Wainwright, national commander of Disabled American Veterans, calls Hoover Commission's suggestions for economy in V.A. hospital program

# RESMICON

*for peptic ulcer therapy*

**relieves pain** The anion-exchange polyamine resin in Resmicon rapidly inactivates HCl and pepsin by physical adsorption. Pain is swiftly relieved.

**promotes healing** The mucin in Resmicon coats the eroded area with a tough, tenacious surface which fosters healing by protecting the ulcerated mucosa.

**acts rapidly** Thoroughly chewed, Resmicon tablets usually relieve the pain of peptic ulcer in about five minutes and with equal rapidity abolish the distress of hyperacidity.

# acid
# adsorbent
# demulcent

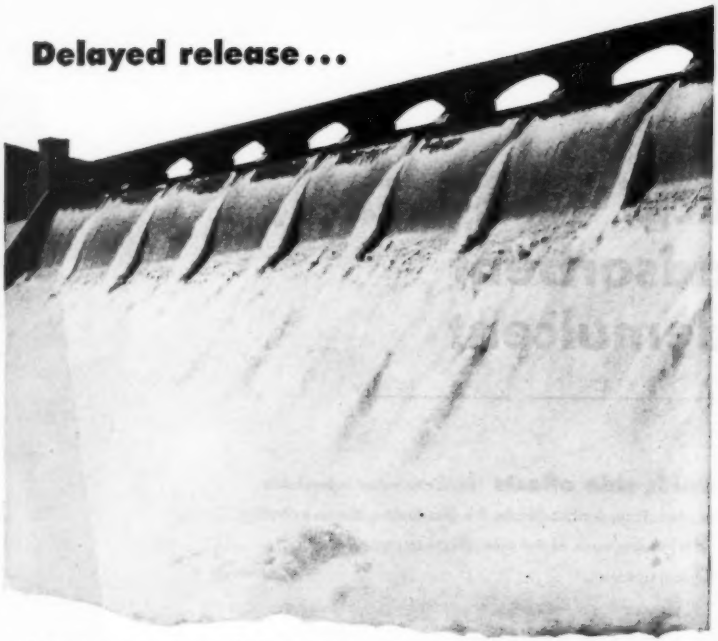
**avoids side effects** Resmicon resin is insoluble and, therefore, unabsorbable. It is non-toxic and non-irritating. And it induces none of the side effects so common with chemical antacids.

## RESMICON tablets

anion-exchange polyamine resin, 500 mg.; gastric mucin, 170 mg.; supplied in bottles of 84 tablets.

Whittier
LABORATORIES
DIVISION NUTRITION RESEARCH LABORATORIES
CHICAGO 30, ILLINOIS

# Delayed release...



Just as a great dam stores and releases water only as fast as the fertile lands below can utilize it, so does Alhydrox* adsorb antigens and release them *slowly* from tissue after injection. This gives the effect of continuous small doses.

**Alhydrox is a Cutter exclusive**—developed and used by Cutter for its vaccines and toxoids. It supplements the physician's skill by producing these immunizing advantages:

1. *Alhydrox selectivity controls the absorption of antigens, reducing dosage volume while building a high antibody concentration.*

2. *Alhydrox, because of its favorable pH, lessens pain on injection and reduces side reactions to a minimum.*

3. *Alhydrox adsorbed antigens are released slowly from tissue, giving the effect of small repeated doses.*

* *Trade name for Aluminum Hydroxide Adsorbed*

*Specify these Cutter* **Alhydrox** *Vaccines:*

- **Pertussis Phase I Alhydrox**
  *30,000 million H pertussis per cc.*
- **Tetanus Toxoid Alhydrox**
- **Diphtheria Toxoid Alhydrox**
- **Diptussis Alhydrox®**
  *Cutter Diphtheria Toxoid plus 20,000 million H pertussis per cc. for simultaneous immunization against pertussis and diphtheria.*
- **Diphtheria Toxoid-Tetanus Toxoid Alhydrox**
  *For simultaneous immunization against diphtheria and tetanus.*
- **Dip-Pert-Tet Alhydrox****
  *Cutter diphtheria, pertussis, tetanus combined vaccine for simultaneous immunization against diphtheria, pertussis, tetanus.*

***Trade Mark*

*Your Cutter dealer has* **Alhydrox** *vaccines in stock*

***Alhydrox is exclusive with*** **CUTTER**

CUTTER LABORATORIES · BERKELEY 10, CALIF.

"shameful" and "complete breach of faith between this Government and its war defenders" . . . An 84-year-old man is accused of defrauding V.A. hospitals by affecting irregular heartbeat. Medical history records only twenty-one cases of persons able to control own heart action . . . Hot last month? Buck up. Humans can stand up to 240 degrees, says Dr. John Margarber, director of University of Illinois Aeromedical and Environmental Institute.

Two Bronxites running a "Holy Temple of Knowledge" have been nabbed for practicing medicine without a license. Law caught up with Professor Baboo, 80, and Prince Ali Sadhoo, 69, when they followed up a crystal-ball reading by trying to sell abortion medicine to two policewomen.

Gift of $2 million will enable Yale University to expand activities in field of student psychiatric guidance . . . Radio and press correspondents polled by Look magazine chose Robert A. Taft (R., Ohio) as Senator who "contributes the most to his country's welfare" . . . Like alarm clocks, new telephones scheduled for 1950 production can be regulated to ring loud or soft.

AMA drawing up code of ethics to guide magazine and newspaper science writers who report medical information to laymen . . . Maintaining that "the masses of Americans are not receiving adequate medical care," Central Conference of American Rabbis has come out in support of compulsory health insurance . . . Fish story to end them all is Chicago Dr. Ole C. Nelson's on how he caught fifty-six bass in one day: "I dipped a crab in benzedrine and tied him to my line. Each time he hit the water he dived down and grabbed a bass with his claws."

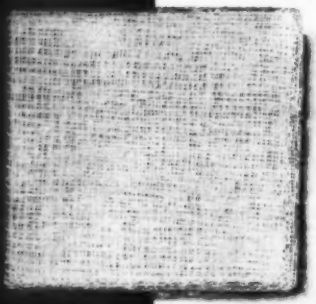
Hahnemann Medical College of Philadelphia, following probation period, now enjoys full approval of AMA Council on Medical Education and Hospitals . . . Says Dr. Bernard Meyer, of Physicians' Forum, "It is quite impossible to substantiate any contention that an overwhelming majority of

Ever prescribe

# Carbas. Absorb. Steril.?

No. But you use it almost every day. Just in case you'd like to know, it's *Carbasus Absorbens Sterilis*—sterile gauze.

Were you to prescribe it though, you would certainly select your gauze with the same discrimination which determines your choice of pharmaceuticals. And when you specified RED CROSS STERILE GAUZE PADS you would note these outstanding features—



**More gauze by weight per pad**
150 square inches folded into each 3 by 3 inch pad to give 16 thicknesses of gauze

**Quicker, greater absorption**
Absorbs 18 times its own weight in less than 3 seconds

**Assured sterility**
Protective envelopes doubly seal-folded on all sides

**Greater dressing volume**
Soft, voluminous fluffs for large dressings

**Whiter appearance**
Pure white gauze with even lower ash content and water extractives than allowed by U. S. P. standards.

RED CROSS
STERILE GAUZE PADS

Johnson & Johnson

This product has no connection whatever with American National Red Cross.

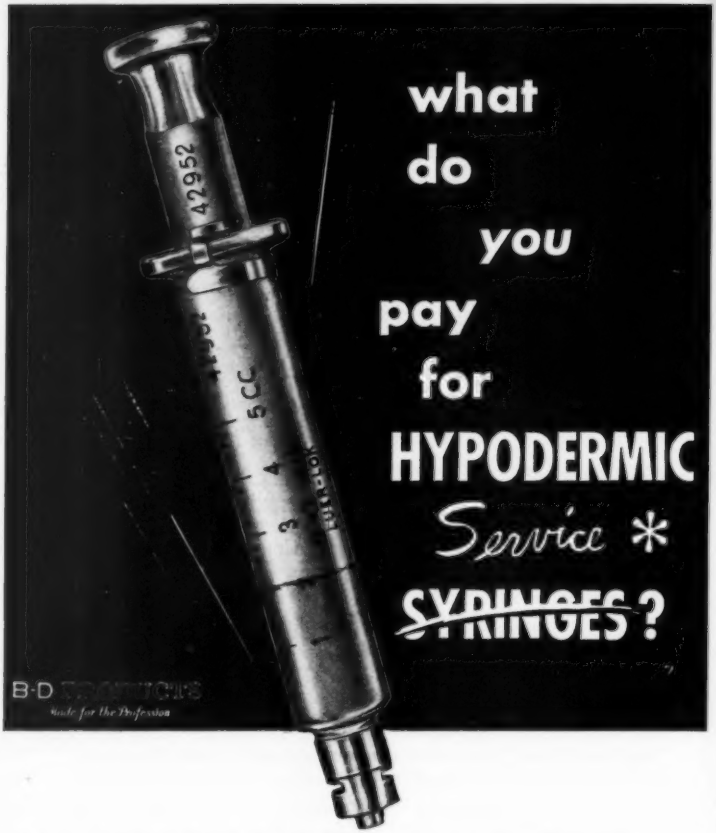
American physicians is opposed to national health insurance" . . . One thousand t.b. patients in Genoa, Italy, staged hunger strike for better food, more liberty . . . "Psychosomatics and Hypnotism in Dentistry," by Dr. Andrew E. McDonald, New Orleans dentist, is first book on dental subject to be written by a Negro.

Anonymous benefactor describing himself as "grateful patient" has donated $200,000 to University of Pennsylvania medical school . . . Newly appointed director of Massachusetts General Hospital is Dr. Dean A. Clark; for the past four years he's directed medical services of controversial Health Insurance Plan of Greater New York.

New "High School of the Air," broadcast by the New York City Department of Education, brings classes to homebound children. Social studies and English being beamed as starters . . . Another medical society takes its story to public through newspaper ads; San Diego County Medical Society buys space to urge enrollment in prepay plans, pledge "services of a physician to all who need them, regardless of ability to pay" . . . Ohio, repealing law that forbids Christian Science practitioners to charge for services, is last state to do so.

Labor leaders meeting with AMA to help implement latter's industrial medicine program. First conference, in Washington, was attended by representatives of CIO, AFL, NAM, and U.S. Chamber of Commerce . . . Physicians and engineers join forces to study industrial health problems in new course offered by New York University's College of Engineering in cooperation with Bellevue Medical Center . . . Safety spectacles incorporating sheets of plastic in lenses are latest wrinkle to protect children's eyes from hazards of BB guns, arrows, slingshots.

Campaign to bring doctor-lecturers before all of Pennsylvania's 1,000 service clubs (Rotary, Kiwanis, etc.) was staged in connection with state medical society's centennial.

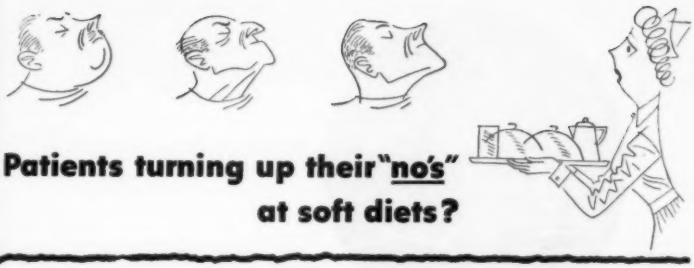



*A hypodermic *syringe* furnishes hypodermic *service* to the extent that it stands up under constant use, repeated sterilization and ordinary handling. What you pay for HYPODERMIC SERVICE depends, not on the initial cost of the syringe alone, but on how long a life of service that syringe gives.

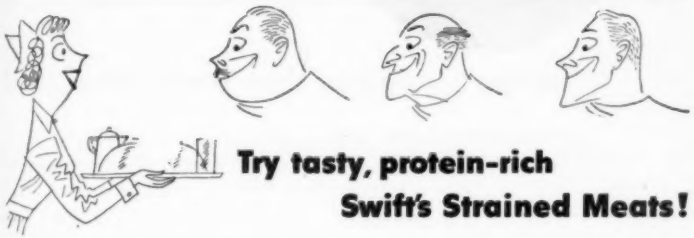
To find out what it is costing *you* for HYPODERMIC SERVICE, send for a free supply of B-D HYPODERMIC SERVICE ACCOUNT RECORD forms and check your purchases and replacements for a month, a quarter or a year. Address your request to Dept. 21-J.

For best results, always use a B-D Needle with a B-D Syringe.

**BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.**



## Patients turning up their "no's" at soft diets?



## Try tasty, protein-rich Swift's Strained Meats!

*Palatable, natural source of complete, high-quality proteins for patients on soft, smooth diets*

To help overcome anorexia many doctors now recommend Swift's Strained Meats. Delicious, *real* meat that patients on soft, smooth diets can eat and *enjoy*. Swift's Meats provide an excellent base for a high-protein, low-residue diet. Rich in iron, they're chemically and physically non-irritating. They make *all* the essential amino acids available *simultaneously* for optimum protein synthesis.

Swift's Strained Meats are tasty enough to tempt tired appetites. They supply goodly amounts of B vitamin to help stimulate patients' natural appetite for other foods. Swift's Strained Meats are 100% meat—a variety of six kinds: beef, lamb, pork, veal, liver, heart. Originally prepared for infant feeding, they're exceptionally fine in texture—may easily be used in tube feeding.


*The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physicians' handbook of protein feeding, written by a doctor. Send to:*


For patients who can take foods of less fine consistency—Swift's Diced Meats—tender morsels of nutritious meats. Tempting flavors patients appreciate

**SWIFT & COMPANY**
Chicago 9, Illinois

*All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.*

## "seven . . . eight, lay them straight"

'Procebrin' (Pan-Vitamins, Pediatric, Lilly) combines eight vitamins in a concentrated solution to help Johnny's bones grow straight, his body strong.

The fat-soluble vitamins A and D in 'Procebrin' are dispersed in a solution which assures absorption even when fat digestion is impaired. Uniform utilization, independent of the digestive process, adds greater efficiency to a plentiful formula.

Dropped on the tongue, the dose of 'Procebrin' has a pleasing taste. When diluted in milk or orange juice, it is quickly dispersed and is not easily detected.

**Each 0.3 cc. of 'Procebrin' contains: Vitamin A, 3,000 units; Vitamin D, 800 units; Vitamin $B_1$, 1 mg.; Vitamin $B_2$, 0.5 mg.; Nicotinamide, 8 mg.; Pantothenic Acid (as Sodium Pantothenate), 1.5 mg.; Vitamin $B_6$ Hydrochloride, 0.5 mg.; and Ascorbic Acid, 60 mg.**

**prescribe**

# PROCEBRIN

**in 15-cc. packages**

*Lilly*

**ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.**

# *Speaking Frankly*

## Giveaways

There is a slow but definite trend toward the reduction of physicians' fees even though prices of other commodities and services are at an all-time high. Some large business organizations, such as the Consolidated Edison Company, are hiring physicians at salaries of about $3 per hour to take care of employes. A great many of these employes, incidentally, ordinarily could afford to pay a private physician's fee.

Doctors taking these positions are giving their services for almost nothing, thereby jeopardizing their own future and that of their private-practice colleagues. Unless physicians organize to prevent such waste of medical services, we will soon be expected to render our services gratis to all!

M.D., New York

## Contradiction

In your Sixth Survey, you report this interesting contradiction: "Oddly, doctors with secretaries collect 87 per cent of their accounts while doctors without secretaries collect 89 per cent. This unnecessary condition could be corrected by better selection, training, and supervision of secretarial personnel."

Then you add: "The biggest employe roster reported by a solo physician totals 18 (4 secretaries, 12 technicians, 2 M.D.'s). The employer is a New England internist. His annual payroll is $34,500."

This internist is certainly underpaying his help. No wonder secretaries lack desirable qualities.

Doctor's Secretary
Boston, Mass.

## Blackmail

Your June article, "The Facts on a Doctor Draft," says: "Medical societies, hospitals, and medical schools were urged to put the heat on some 8,000 men who had been trained at Government expense but who had never served in the armed forces."

This statement exemplifies the widespread, uncritical acceptance of the policy of subtle blackmail directed at physicians trained under Government auspices during the war. These training programs were operated at the convenience of the Government. The men who participated in them were so assigned because it was felt they could render maximum service to the war effort in that capacity. They were

under military command and subject to reassignment to the same extent as were those in other military assignments.

I feel strongly that we owe it to our young physicians to acknowledge the dignity of their wartime service as we would acknowledge that of any other serviceman.

W. H. Stover
Lowe Clinic and Hospital
Mobridge, S. D.

## 'Turkey'

I have just read two pamphlets against Government-controlled medicine, put out by the National Education Campaign of the AMA, which is run by Whitaker & Baxter.

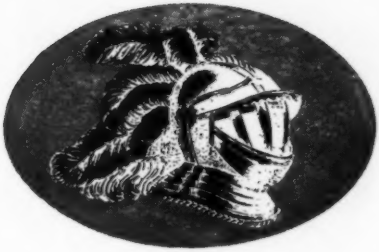
I think they stink.

If these booklets are a sample of what we've bought with our $25 assessments, we've got what the vaudevillians call a "turkey."

Take that Luke Fildes picture of the shabby, bearded doctor, eyeing his patient by the light of a kerosene lamp. There's a chestnut for you! It has about as much relation to the crisp, somewhat over-efficient attitude of the modern practitioner as the sailboats of Christopher Columbus have to an up-to-date battleship.

If our high-priced experts can't dream up anything better than that, they had better take a deep sniff of benzedrine.

The text of the pamphlets lacks punch, too. It's wordy. It's repetitive. And it fairly drips clichés. It has, altogether, about as much reading appeal as a dictionary.



# Protective covering . . .

*Gelusil* Antacid Adsorbent*, an especially prepared, nonreactive aluminum hydroxide gel, protects the inflamed or ulcerated areas of the gastric mucosa against injury by the acid gastric juice. Unlike most aluminum hydroxide preparations, *Gelusil* Antacid Adsorbent* is nonconstipating.[1]

## Gelusil* 'Warner'

*Antacid Adsorbent*

***Gelusil* Antacid Adsorbent***

provides rapid and sustained relief of gastric hyperacidity and is particularly effective as an adjuvant in the medical management of gastric or duodenal ulcer.

is available as a pleasant-tasting liquid or tablet.

Liquid—6 and 12 fluidounces.

Tablets, individually wrapped in cellophane—boxes of 50 and 100 tablets. Also bottles of 1000.

[1]Rossien, A. X., and Victor, A. W.: The Influence of An Antacid on Evacuation of the Bowels and the Fecal Column, *Am. J. Dig. Dis.*, *14*:226, July, 1947.

William R. Warner & Co., Inc.

New York St. Louis

*T. M. Reg. U. S. Pat. Off.

When we hand our patients printed material on this subject, we want to strike sparks, not put them to sleep.

The best part of the publicity is reserved for Whitaker & Baxter. Their names are plastered all over the stuff. Just what are we paying for: to publicize the public relations firm, or the aims of the campaign?

Amy Weiss, M.D.
Chicago, Ill.

## Veto

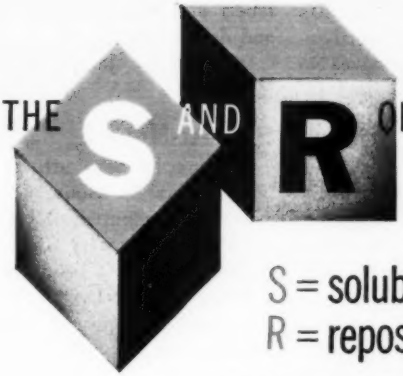
Can you tell me why the Bureau of Internal Revenue doesn't allow the costs of post-graduate medical study to be counted as a professional deduction on Federal income tax returns?

M.D., New Jersey

*The Treasury Department says: "Existing legislation has been uniformly interpreted by the Bureau of Internal Revenue and the courts to classify educational expenses as personal costs and, therefore, not deductible for income tax purposes. In theory, these expenses are in about the same category as the capital which a business man might invest in his business, and which is likewise not deductible."*

## Wishful

In your June issue, a physician concludes that a depression or recession will spell finis for Mr. Ewing's compulsory health insurance plan. This may prove more wishful than accurate. [*Continued on* 30]




S = soluble
R = repository

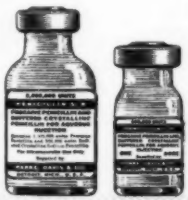
Two forms of penicillin combined to
give the inherent advantages of both

PENICILLIN S-R **ALSO MEANS SPEEDY RISE**
of blood penicillin level – twenty times higher than procaine penicillin in oil – within a half hour or less.

PENICILLIN S-R **MEANS SUSTAINED RESPONSE**
to a 1 cc. intramuscular injection – prolonged effective levels for 24 hours or longer.

PENICILLIN S-R **MEANS SLOW AND RAPID**
absorption from the Parke-Davis combination of procaine penicillin (controlled crystal size), 300,000 units, and buffered soluble penicillin, 100,000 units.

PENICILLIN S-R **MEANS SIMPLIFIED ROUTINE**
in penicillin therapy – no oil, wax or suspending agents to impede injection and clog syringe and needle. Prepared with aqueous diluent, PENICILLIN S-R needs no vigorous shaking and flows freely.



PENICILLIN S-R
is supplied in one-dose (400,000 units), five dose (2,000,000 units), and ten-dose (4,000,000 units) vials. When diluted according to directions, each cc. contains 300,000 units of crystalline procaine penicillin-G and 100,000 units of buffered crystalline sodium penicillin-G. The one-dose vial is also available, if desired, with an accompanying ampoule of Water for Injection, U. S. P.

**PARKE, DAVIS & COMPANY**
DETROIT 32, MICHIGAN

MEDICAMENTA VERA · PD CO.

It was the depression of the 30's that gave impetus to the social security legislation we now have. No doubt a new depression will increase the demand for national health legislation. And, as in the 1930's, many physicians may welcome the income from public medical care projects.

L. A. Eldridge Jr., M.D.
Rensselaerville, N.Y.

## Bath

Your April issue mentioned an electric water cooler that may also be used for cold-storage of pharmaceuticals.

In my experience with such units, there's a tremendous amount of moisture in the cold-storage compartment that soaks through the labels and boxes of the vaccines and destroys them.

Jac. Gillman, M.D.
Jamaica, N.Y.

## Stay-At-Homes

I couldn't let your article, "Nine Time-Savers for House Calls," go without a rebuttal. Most house calls are unnecessary. Patients can be told, "Yes I will be glad to make a house call, but I won't be able to help you as much as I could if an examination were done at the office."

About half will then decide to come to the office—especially when they also learn that a house call often costs as much or more than an office call plus a laboratory test or X-ray. [*Continued on* 32]

Another advantage is that a more complete examination can be performed on an examining table than on a soft, sagging bed. A better history can be taken. Urinalysis and blood count can be performed as a minimum.

How many house calls are necessary? I don't know. I rarely make a house call for a child who is small enough to be carried into the office.

In an average practice in a town of 3,000 I make only two or three house calls weekly.

Ralph L. Gorrell, M.D.
Clarion, Ia.

## X-Rays

It was good to hear that Philadelphia, Detroit, Tucson, and San Antonio are protecting restaurant patrons by requiring waitresses to have X-ray examinations. Now let us hear our cities report that, for the protection of patients, all nurses and hospital attendants must have X-ray examinations also.

I could not estimate how many cities or states can presently make such a report, but I do know there are many that will have to remain silent.

Leopold Brahdy, M.D.
New York, N.Y.

## Cinematic

Commenting on the film, "The Case of Mrs. Conrad," you said, "Critics noted an authenticity about the surgical scenes that had been conspicuously absent in many others stemming from Hollywood." Had

the critics been a little more observant, they would have noted an acknowledgement to the New York Academy of Medicine. A special subcommittee of its medical information bureau cooperated with the March of Time to make certain the documentary was authentic.

Iago Galdston, M.D.
New York, N.Y.

## Discrimination

Every time I read about restricting surgical privileges to "safeguard the patient," I have to laugh. Those who would let only a chosen few enjoy the lucrative benefits of operating usually are interested in their purse rather than the patient's welfare.

I defy anyone to produce evidence that one must have two years of residency to do an appendectomy or hernioplasty. By the same token, one should have two years of residency to deliver a baby or treat diabetes. Why all the emphasis on operating and surgery only?

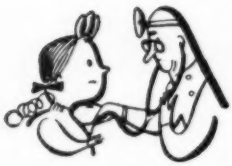
Stanley G. Sedlar, M.D.
Carey, Idaho

## Elections

The only thing that will prevent socialized medicine is to send at least one M.D.-Representative to Congress from each of the forty-eight states. It's possible that a few physicians could also be elected to the Senate. Why doesn't the AMA start preparing a slate for the 1950 elections?

Fred Irwin, M.D.
Honolulu, T.H.

# Help For Your OBESITY Problems



To help you put overweight patients on the road to health —to help them reduce safely and *maintain normal weight after reduction*—send for these useful booklets: "Low-Calorie Diets," 1200 and 1800-calorie diets for adults; "Through The Looking Glass," 1500-calorie diets for teen-age girls. **They can save you many hours of consultation time.**

Diets in these booklets are carefully balanced to supply essential nutrients. Exact sizes of servings are given so no calorie counting is necessary. Psychological factors are considered, to help overcome desire for high-calorie food. Thus the lasting benefits of "stay slim" habits are acquired.

**Ry-Krisp:** only 23 calories per wafer, bulk for satiety, all the protein, minerals and vitamins of whole-grain rye.


**USE COUPON FOR FREE BOOKLETS**

RALSTON PURINA COMPANY, Nutrition Service
ME-12 Checkerboard Square, St. Louis 2, Missouri

Please send (indicate quantity):

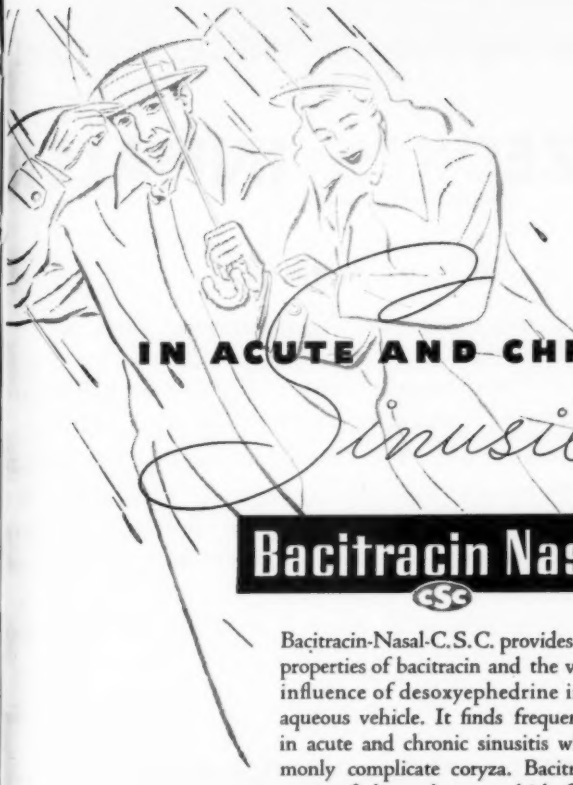
_____C3049, "Low-Calorie Diets"- - - - - - - - Imprinted? Yes ____ No____

_____C966, "Through the Looking Glass"

Name_____M.D.

Street_____

City_____Zone____State_____



## IN ACUTE AND CHRONIC *Sinusitis*

# Bacitracin Nasal

CSC

Bacitracin-Nasal-C.S.C. provides the antibiotic properties of bacitracin and the vasoconstrictor influence of desoxyephedrine in an isotonic aqueous vehicle. It finds frequent application in acute and chronic sinusitis which so commonly complicate coryza. Bacitracin destroys many of the pathogens which flourish in the nasal passages and accessory nasal sinuses thus providing a means of directly combating infections in these structures. Desoxyephedrine by its local vasoconstrictor action improves ventilation and drainage, and enhances the effect of the bacitracin. Bacitracin-Nasal-C.S.C. may be administered by means of a nebulizing spray or by the Parkinson lateral head low position. Available in ½ ounce bottles on prescription at all pharmacies.

When dispensed by the pharmacist each cc. of Bacitracin-Nasal-C. S. C. provides: bacitracin approximately 250 units and desoxyephedrine hydrochloride 2.5 mg. (0.25%). The solution is stable at room temperature for 5 to 7 days; at refrigerator temperature for 3 to 4 weeks.

*C.S.C. Pharmaceuticals*

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION • 17 E. 42nd St., N. Y. 17, N. Y.

Announcing the new S.K.F. Inhaler!

# BENZEDREX INHALER

*So much better that*

*we have discontinued 'Benzedrine' Inhaler*

'BENZEDREX' INHALER is such a major improvement that we are actually withdrawing 'Benzedrine' Inhaler from the market.

The active ingredient of BENZEDREX INHALER is 1-cyclohexyl-2-methylaminopropane, a new S.K.F. compound. It has exactly the same agreeable odor as Benzedrine*, gives even more effective and prolonged shrinkage, and does NOT produce excitation or wakefulness.

We are sure you will find that BENZEDREX INHALER is the best volatile vasoconstrictor you have ever used.

*Smith, Kline & French Laboratories, Philadelphia*




*'Benzedrine' (racemic amphetamine, S.K.F.) and 'Benzedrex' T.M. Reg. U.S. Pat. Off.

# Sidelights

## Capital Strategy

Should medicine take a more active role in helping to draft national health legislation?

Three years ago the AMA delegates blackballed the idea. "In our opinion," they resolved, "it would be most unwise for the association to become legislation-conscious . . . It is an organization with scientific objectives. It should remain so."

That decision planted medicine squarely on the horns of a dilemma. Ever since, Congress has been peppered with impracticable health bills schemed up by political planners. The AMA is morally bound to criticize them. Yet these enforced dissents contribute to the public impression that the AMA is "defensive and negativistic."

As a matter of fact, there's no good reason why our national association should *not* become "legislation-conscious." It is already active in such diverse fields as medical economics, health insurance, and public relations. What's more, there are plenty of signs that continued failure to take the lead in the realm of health legislation will simply fling the gates wide open for compulsory health insurance.

All of which plays up the importance of a recent AMA decision. At Atlantic City in June, the delegates voted to set up a legislative action committee representing the AMA's higher echelons. The committee will call periodic conferences with Congressmen in a drive to develop health legislation along AMA-favored lines. One of its first jobs, for example, will be to push for a blend of the Hill and Taft health bills.

This idea, in our opinion, is top-drawer. We hope the AMA committee gets to work pronto, with the association's full resources at its disposal. It could turn out to be the legislative spearhead this country's medical men have long needed.

## Taste and Try

"The green medicine seemed to help." It's nice to hear that from a patient—provided, of course, you happen to know which of your prescriptions produced a green liquid.

Time was when the M.D. selected the vehicle for the Rx and knew pretty well what the finished product looked like. Today, the average senior medical student knows all about the pharmacology of tincture of digitalis, but has

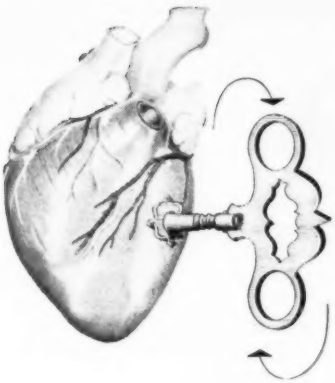
never actually seen a bottle of it.

So too with tablets. They vary in color, size, shape, and scoring. Unless the doctor has seen the tablet he is prescribing, he does not know, for instance, whether it is scored for breakage into half doses. He's similarly in the dark on the taste and odor of most modern medications. Under present conditions, few M.D.'s really know what the finished Rx looks like—which may be embarrassing.

That is why one midwestern physician, stymied by a patient's request for "more of that pink, syrupy medicine you prescribed last month," decided to learn once and for all what the commoner medicines looked, smelled, and tasted like. He called on his neighborhood pharmacist and spent nearly two hours peering, sniffing, and tasting. "It was a well-spent afternoon," he admits. "Now, when I write a prescription, I do so with some additional confidence. I can tell the patient exactly what to expect."

## Sugar Coating

At breakfast the other morning with H. Guy Radcliffe Drew, chairman of the Institute of British Surgical Technicians, we mentioned a report that the health of the British people, despite stringent food rationing, was improving steadily. "Yes," said our guest, "and it will continue to improve as long as the Government puts out statistics on it."



if only it were this –SIMPLE

Until there are mechanical means for winding-up the failing heart . . . consider this: Nativelle isolated Digitaline to minimize the disadvantages of whole leaf. He replaced variable results with the *predictable effects* of dosage by weight. Digitaline Nativelle digitalizes in a few hours and *maintains the maximum efficiency obtainable. This maintenance is positive!* Complete absorption and a uniform rate of dissipation provide full digitalis effect between doses. Elimination of crude substances virtually eliminates side effects.

# Digitaline Nativelle

*Chief active principle of digitalis purpurea (digitoxin)*

*Ease of Administration*

**RAPID DIGITALIZATION** . . . 1.2 mg. in equally divided doses of 0.6 mg. at three-hour intervals. **MAINTENANCE:** 0.1 or 0.2 mg. daily depending on patient's response. **CHANGE-OVER:** Prescribe 0.1 or 0.2 mg. of Digitaline Nativelle to replace maintenance dosage of 0.1 gm. or 0.2 gm. of whole leaf.

Send for brochure "Modern Digitalis Therapy" Varick Pharmacal Co. Inc. (Div. E. Fougera & Co. Inc.) 75 Varick St., New York

**Because "SUDDEN" is a dangerous word in cases of hypertension...** it has become almost instinctive with physicians to prescribe Nitranitol. An ideal vasodilator, Nitranitol produces *gradual* reduction of blood pressure in essential hypertension. Nitranitol maintains lowered levels of pressure for prolonged periods. Virtually non-toxic, Nitranitol is safe to use over long periods of time.

# NITRANITOL®

***For gradual, prolonged, safe vasodilation***

Merrell
1828
CINCINNATI • U.S.A.

**When sedation is desired.** *Nitranitol with Phenobarbital.* (¼ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

**For extra protection against hazards of capillary fragility.** *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

# Editorial

## Medicine's Right Wing

• Every once in a while this magazine gets a letter phrased about as follows: "Why all the talk about how far we should permit government to invade medicine? Government has *no business at all* in the field of health care."

Such letters are much rarer now than formerly. Yet occasional ones still reflect an unrealistic and deleterious frame of mind on the part of a small segment of practitioners.

It is unrealistic because it ignores the fact that government has been actively concerned with the health care of its citizens for more than a generation.

It is deleterious because those who would socialize medicine make political hay of such views, quoting them as evidence of the "negativism" of our profession as a whole.

We won't get anywhere simply by bewailing the socializers' tactics. They are the time-honored tactics of all socializers everywhere. But we *can* render them useless by closing ranks on high and defensible grounds. These grounds are that there *is* a place for government in medicine—*up to a point.*

We have seen the accomplishments of the Public Health Service. How many physicians believe this agency should discontinue its work in such fields as tuberculosis and VD control?

We have witnessed the strides of the Veterans Administration medical program. How many doctors feel that veterans should be denied free care for service-connected disabilities?

For the overwhelming majority of medical men, the question of government in medicine is not "whether," but "how much." Virtually all of us favor at least some of the established PHS and VA activities. Many favor expanded aid for the medically indigent; the important thing is *how* and *to whom* this aid should be extended.

These are the vital issues. On these the main body of our profession has advisedly taken its stand.

Yet, in the midst of the battle, medicine's right wing remains exposed to effective sniping by the socializers. This exposed wing is, of course, the little group of physicians who cling resolutely to their by-passed outpost of opinion.

It's time they rejoined their colleagues, over where the shooting's going on.

—H. SHERIDAN BAKETEL, M.D.

# Investment Trusts for the Doctor?

***Many went sour in '29, some are still sour; others offer good opportunities***

● More and more doctor-investors today are casting an interested eye at modern finance's fast-growing phenomenon: the investment trust. Some trust shares, they have found, pay over 7 per cent income. Others, with reinvestment of dividends, have gained more than 200 per cent in value in the past twelve years. Additional trust advantages:

¶ Investment diversification, no matter how small the investor's kitty.

¶ Professional management of investments, at a price within the smallest investor's means.

Here's how these advantages come about:

Essentially, an investment trust is a cooperative for investors. You join it by buying one or more of its shares. The money you pay in is invested by the trust's management, along with the funds of other shareholders, in stocks and bonds. With the pooled resources of many investors, the trust can invest in a broader list of securities than can the average lone investor. And its trained management can usually do a better job of picking securities, of timing their purchase and sale.

Each share of trust stock you own is a fractional claim against the trust's entire assets. Thus, the value of your shares will tend to rise or fall with the total value of the stocks and bonds held by the trust. Proportionate to the number of your shares, you participate with other shareholders in the trust's dividend income and security profits, less management salaries and other operating expenses.

### *How They Started*

Investment companies were popular in Scotland and England seventy years ago, and King William I of Belgium is credited with dreaming up the first one some sixty years before that. They were

---

NOTE: *This article is the first of several on investment trusts. The second will appear next month. Much of the statistical and other information given is drawn from "Investment Companies," 1949 edition, published at $15 by Arthur Wiesenberger & Co., New York.*

introduced in this country during the 1890's, the oldest one now being the Boston Personal Property Trust, which is still going strong.

The trust idea didn't catch on in a big way until the razzle-dazzle days of the late 1920's, when investment companies burgeoned in Wall Street like dandelions in May. What happened to most of them after the big fall frost of 1929 is what soured them in the public mind for nearly a decade.

But the basic theory of investors' cooperatives was too attractive to be junked for good. Wide-awake security buyers began noticing that some trusts had weathered the gale in remarkably good shape. The Government itself, though it later laid down some much-needed ground rules for investment trusts, was among the first to let bygones be bygones.

Over ten years ago the Securities and Exchange Commission, Federal watchdog of Wall Street, called the growth of investment trust companies "probably the most important single development in the financial history of the United States during the past fifty years."

Yet their real growth wasn't to get under way till around 1940. Since then the eighty-seven biggest "open-end" trusts have more than tripled their assets, to $1½ billion, and doubled their shareholders, to some 730,000.

This is still small potatoes compared with the nation's 80 million holders of $55 billion of U.S. savings bonds, its 78 million claimants to $50 billion of life insurance assets. But buyers of corporate stocks and bonds have always been a tiny minority of the investing public.

The point is that, of an estimated 6 million corporate security investors, about one out of six (including holders of "closed-end" trust shares) now do some or all

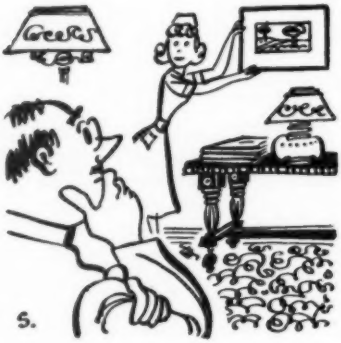
## The Army Way

● During my Army stint I decided to prepare a paper for my home state medical journal. I put my enlisted staff to work abstracting chart data and assigned to a bright young sergeant the job of averaging the long columns of statistics. Finally he handed me the results: the patients' average age, average hospital stay, average this and average that. On the last sheet, for good measure, he had included a figure that I suspect reflected his view of the value of all the others: a carefully computed average of the patients' case history numbers. —SAMUEL B. THOMPSON, M.D.

of their investing through investment trusts. Nor are they confined to doctor, lawyer, or union chief; many large investors, estates, universities, and other institutional coupon-clippers have swung over to investment company shares.

Investment trusts fall into two main categories: (1) closed-end companies and (2) open-end, or "mutual," companies.

The closed-end company has a fixed capitalization, like any ordinary business corporation. Its shares are usually traded on a stock exchange. If you want to buy into a closed trust, you must place an order with your broker to buy the shares from another investor with holdings to sell. The price you pay will be governed not only by the per-share asset value—that is, the net value of the trust's security holdings divided by the number of its shares—but by supply and demand factors. If the trust is particularly well thought of, you may have to pay a premium over the asset value of its shares; if it's in the doghouse, you can probably pick up the stock at a discount.




Newer and more popular are the mutual trusts. These issue new shares at any time, on demand from buyers. They also stand ready to buy back previously issued shares from investors who want to cash in their holdings.

Shares are offered by the mutual trust, through its salesmen or authorized dealers, at the current per-share asset value, plus a "loading charge." This charge, to cover selling costs, is made as a rule on sales only; the redemption price of the shares is usually based on their straight asset value. The loading charge is comparable to the combined purchase and sale commissions you pay a broker when you buy and later sell the stock of a closed-end trust or any other publicly traded security.

But these technical distinctions between open- and closed-end companies, though important, should not be overemphasized. More basic from an investment standpoint are the management policies and other characteristics of individual trusts in both the open and closed categories. The informed physician, seeking a long-term solution to his investment problem through one or more trusts, knows he must first invest enough time for an inspection of the field and for the selection of trust shares suited to his own investment needs. —H. D. STEINMETZ

# Give the Patient a Fee Estimate

***Some practical suggestions on how best to go about it***

• Is there a horse-trader in your family tree? No? Then you probably have as much trouble as the next fellow when the patient asks you to estimate the cost of a series of treatments, a delivery, or an operation.

Should you give an estimate at all? How to evaluate the patient's reasons for asking? What practical diplomacy to use in phrasing your reply?

Summarized below is the pooled experience of some thirty physicians who have sought and found workable solutions to these problems. In a series of interviews, these men were asked to discuss the pros and cons of estimating fees and to

explain the methods that they use.

Is it wise to estimate a fee in advance of treatment, when requested by the patient?

Majority opinion says yes. The specific advantages of giving an estimate are revealed in these typical quotations:

*An estimate is a help to budgeters.* "Most of my patients are the kind who have to plan for payment. I try to help by quoting the exact cost of treatment, upon request. If such a figure is not completely predictable, I give minimum and maximum estimates. The patient usually is able to arrange his budget accordingly, particularly if I indicate a willingness to accept time payments. I recognize that the time-payment principle is open to abuse; but patients who are frank enough to discuss the question in advance are seldom troublemakers in this respect. . ."

### *Keeps Them Coming*

*It helps to keep patients under treatment.* "Patients are naturally reluctant to begin a prolonged course of treatment without having some idea of the ultimate cost. If they begin anyway, without settling this uncertainty, they may become hesitant about coming back as often as is necessary. Sometimes they drop out before the doctor has a chance to do them any real good. Rather than lose a patient this way, I always give an advance estimate."

*It helps to justify the final bill.* "As a surgeon, I know that thorough discussion of the fee *before* the operation is of great value in eliminating fault-finding when the bill is finally presented. It does away with the following sentiment, once expressed to me by an indignant patient: 'I'd never have had the operation if I had known it was going to cost that much'. . ."

*It helps to settle collection worries.* "A specialist is commonly asked for an estimate. It does no good to say, 'Now don't let's worry about that now; we'll discuss it later.' I tried that technique for a while. Trouble was that it left *me* to worry about the fee and when it would be paid. So I always estimate. In fact, if a major piece of work is in prospect, and the patient *doesn't* inquire, I bring the question up myself."

*It helps the doctor to set a fair charge.* "Most of my patients are budget-minded. Nevertheless, it requires a certain amount of courage for them to bring up the question of fees. I try to keep that in mind. The patient who asks for an estimate gives me the perfect opportunity to discuss the size of the fee and to adjust it fairly according to his ability to pay. . ."

Assuming a discussion of the fee is warranted, how to start off? Here are some pertinent pointers:

*Give a flexible estimate.* "I try to estimate an all-inclusive fee only after a thorough examination and a discussion of the proposed therapy with the patient. If there's little chance that complications will

arise, I quote a fairly definite figure. When this is not possible, I carefully explain why, and then give a maximum and a minimum figure. I assure the patient that I will do all I can to achieve a speedy recovery. . ."

*Use the prepay plan fee schedule.* "When a patient asks me for an estimate, I often refer to the fee schedule of our local Blue Shield plan. If the patient has an income of about $50 a week, I charge the fee listed on the schedule. If his income is higher than that, I adjust my fee upward accordingly, though I never set a figure which is more than double the minimum listed. If my fee is ever disputed I have the very best substantiation for the fact that my charge was not excessive. . ."

*Ask the patient first.* "Often it is hard to know what fee to set for an operation. But here's one device that has helped me to arrive at a fair charge: Before the patient has a chance to ask what the operation will cost, I inquire whether he wants a private or a semi-private hospital room, and whether or not he wants a private nurse. His answer gives me something concrete to go on. If he can pay for special care, he can afford a reasonable fee. . ."

*Cover all related costs.* "I give an exact estimate only in operative cases. But I've found that it's not enough simply to quote my fee for the actual surgery. The patient wants to know the total cost from the time he enters the hospital until his recovery is complete. My policy is to tell him, as nearly as I can, the number of days he will be in the hospital, the rates for room and board while hospitalized, the fees for operating room, anesthesia, nursing, surgical dressings, X-ray and laboratory charges, and so on. If it isn't possible to estimate the number of follow-up visits that may be required, I say so. I *have* had patients who felt they could walk in on me indefinitely after an operation, seeking free treatment for ailments having little or nothing to do with the original case. . ."

### *Guaranteed Estimate*

*Put it in writing.* "In my practice—surgery—the only adequate way of giving an estimate is to put it in writing. So I have had special slips made up on which I can list all the charges to be met in connection with an operation. I fill in each entry, give the patient a copy, and keep a copy myself. The patient thus forewarned has no fault to find when he gets my bill. . ."

Occasionally, situations do arise where the wisest policy is to avoid giving an estimate. As a means of getting around a direct inquiry, some of the following methods have been found practicable:

*Emphasize reasonableness.* "I make the point that no two cases are exactly similar. Then I emphasize it by citing one or more examples. I reassure the patient that I will make every effort to mini-

mize the number of calls, and add that I will make the fee as reasonable as possible. The word "reasonable" usually dissipates fear of a heavy bill. . ."

*Describe an average similar case.* "The most I ever do is to give an approximate idea of how long it takes to clear up an *average* condition of the kind under consideration. Then if it takes longer or if other special factors enter into the final cost, I explain in detail the difference between *this* case and the average one. . ."

*Promise a fair charge.* "My prompt reply is, 'I promise you that the fee will be within your ability to pay. It wouldn't be fair either to you or to me if I were to guess at a figure. You may be sure I'll make the length of treatment as brief as possible.' "

Many a patient hesitates to make down payments on services whose final cost he cannot foresee. You can hardly blame him for wanting to settle this uncertainty.

The point is, any quoted figure— no matter how high it may seem to the patient— will do away with this uncertainty. Once you give the estimate, the patient must either agree to the terms or submit legitimate grounds for a satisfactory compromise. A time-payment arrangement, a reduction in the fee, or a combination of the two will provide the necessary meeting ground.

For an example of how an aver-

**"After this expensive consultation, I'm afraid to tell them it's just a cold."**

age case can be handled successfully, consider the following dialogue. It takes place in the office of a physician whom we will call Dr. Danforth; the doctor's secretary, Miss Fulton ,has just entered.

Miss F: That Mr. Little is back again. Says he's having more trouble and wants to see you about those injections you mentioned.

Dr. D: I hate to think of starting him on that course of shots.

Miss F: The expense, you mean?

Dr. D: Yes. As I recall it, he's none too well fixed financially. When the visits begin to mount up, he'll start worrying about the cost. Still, it's the only way I can be sure of helping him. . .

Miss F: Will you see him now?

Dr. D: Yes, show him in.

[*Mr. Little enters. He is a middle-aged white-collar worker, a bit frayed around the edges. After an exchange of formalities, he comes to the point.*]

Mr. L: Well, Doctor, the prescription works fine as long as I keep taking it. But soon after I stop, I get the same old trouble. I'd like to clear this thing up once and for all. I remember you suggested taking some shots.

Dr. D: Yes, I hoped the capsules would do it, but the injections are the best way of making sure. They take time, but they get results.

Mr. L: Well, can you give me an idea of how long it would take?

Dr. D: That's hard to say, exactly. Might take four months— might take five. Certainly no more than six if you came twice a week. Depends on how you respond.

Mr. L: That long? I didn't realize . . . That might run into more than I could pay you, Doctor. Can you tell me how much the whole business would cost?

Dr. D: Well, my regular fee is $3 for each injection, including the cost of the vaccine. Twice a week for four months would be about 34 times 3—around $102. If it took six months that would be about 52 times 3, or $156. Somewhere between the two.

[*A moment of silence ensues while Mr. Little completes the mental exercise of balancing these figures against his budget.*]

Mr. L: I don't know whether I could swing it or not. I know it would take me more than six months to pay. Even at that. . .

Dr. D: Well, I'll try to make it as easy for you as I can. I'll make an exception in your case: Anything over $100 I won't charge you for. Then suppose you pay what you can as we go along, with an idea of settling everything in ten months.

Mr. L: That's very kind of you, Doctor. But I don't like to ask favors. . .

Dr. D: That's perfectly all right. If we can agree on some arrangement like this, it will help clear the way so we can both concentrate on getting you well.

Mr. L: All right, Doctor.

Dr. D: Good! Now, if you'll come right over here. . .

—ALEXANDER WARREN

# Union Medical Plans Set for Boom

***Labor-sponsored health insurance is fastest growing segment of prepay field***

● If you practice much among industrial workers, you'll soon have to get in on a union medical plan—or start losing patients. That's how it looks from the boom that's shaping up in labor's prepay schemes.

Unlike workmen's compensation, the union plans cover illnesses *not* connected with employment. These plans are already big business, encompassing more than 3 million workers. But the real eye-popper is their growth rate: 500 per cent in the last three years. And the big push, say union spokesmen, is yet to come. This autumn's goal: 5 million workers covered.

In 1948 the National Labor Relations Board ruled that group health insurance is a legitimate subject for collective bargaining. Employers now have to talk turkey on medical plans with any unions so minded. More and more unions *are* so minded. Declining living costs tend to spike their arguments for higher money wages; so they're switching to welfare demands—particularly health insurance.

Union medical plans are of three general types: (1) union-operated clinics and medical services; (2) group medical-expense insurance, with workers reimbursed for doctor bills; and (3) group medical-service insurance, with doctors paid direct by insurance carriers (usually commercial companies).

Biggest project in the first category is the $3½ million Manhattan clinic opened by the International Ladies Garment Workers Union (AFL). The ILGWU proposes similar centers in Boston, Philadelphia, and Chicago. Another development of this type is a union-management project of the New York hotel trade. It calls for a million-dollar free clinic for the city's 30,000 hotel employes.

### *What Doctors Like*

Union-operated clinics and medical services are, however, mostly confined to a few big cities or to remote, under-doctored areas (such as mining camps). More popular with most unions, employers, and M.D.'s are group insurance policies. As between the service and indemnity set-ups, many physicians prefer the latter.

Here's the way a typical union indemnity plan works:

Dr. Doe, a general practitioner

in a New England mill town, is called in on a suspected appendicitis. He makes two house calls on the patient, a member of the Textile Workers Union (CIO), then refers him to a surgeon for an appendectomy. Two weeks later the man gets back from the hospital. Dr. Doe sees him twice more at his home, once at the office.

Dr. Doe subsequently collects at prevailing rates: $3 per house call, $2 for the office visit. (The plan allows each worker fifty doctor's calls a year, three in any one week.) The surgeon gets $100. The hospital receives $98 for two weeks of semi-private accommodations ($7 a day). The patient pays and is reimbursed by the insurance company.

The service plans, not quite so simple for the doctor, are more popular with unions and employers —who do the deciding. Here the physician must sign up with union, insurance company, or whatever agency is running the show. Also, he must be prepared to justify his treatment methods in any case where they depart from "normal."

How is union medicine financed? Usually, in one of three ways:

¶ *By the union, through a treasury appropriation or assessment of members.* This is the old method, now obsolescent. It harks back to the days when unions were politically powerless "beneficial societies" and had to offer special membership come-ons.

¶ *By a royalty on the product.* Under a plan begun last fall, for instance, the price of every ton of coal includes a 20-cent tribute to the retirement and welfare fund of the United Mine Workers. When it becomes fully operative, this $130-million-a-year fund will provide cradle-to-grave medical care for more than 450,000 miner-families. Another union using the royalty system is the American Federation of Musicians.

¶ *By the employer, or by joint em-*

*ployer-employe contributions.* This is the coming trend. Emphasis is more and more on complete financing by the employer, joint control by the union. Employers are going along because: (a) they can write off most of the cost as a tax deduction; (b) unions will often accept the plan in lieu of a wage boost; and (c) the plan makes for healthier, happier workers, and cuts labor turnover.

Union medical plans are negotiated as a rule at the local level. The UMW, ILGWU, and Amalgamated Clothing Workers plans are national; but they are exceptions.

### *Aim: More Coverage*

Bellwether among CIO international unions is the million-member United Auto Workers. The strategy being mapped by the UAW for its locals suggests the general trend among CIO units. Last year the UAW set up a social security department, appointed a medical advisory committee of nine nationally-known physicians. For hospitalization coverage, the union has been sticking mostly to Blue Cross. But ultimately it wants more comprehensive hospitalization and medical coverage. It aims to get it in this way:

First, local auto-worker unions are to talk employers into footing the whole bill. (Kaiser-Fraser has already come across; it pays $8-9 per worker per month.) Then each union will write a service contract with a local group of doctors, perhaps in association with a hospital. The UAW wants no indemnity coverage, no clinics of its own. It wants to build up local community medical facilities. It expects its members, as part of the community, to benefit accordingly. Where group practice does not exist, the union hopes to promote such practice.

### *What Unions Want*

To the extent that their program is successful, the auto workers (and CIO) may backtrack some on national health insurance. However, they want free, comprehensive health coverage one way or another. Their present stand is that a national program should be enacted as a minimum standard of protection (comparable to the minimum wage law), with unions free to go as far beyond it as they can via collective bargaining.

The AFL view is hazier. It prefers service plans, but thinks indemnity plans will multiply faster because of the small size of craft-union locals. Some industries where employment is intermittent (*e.g.*, the building trades) aren't very well adapted to group policies of any kind. For this reason, the AFL will probably not deviate from its line in favor of whole-hog national health insurance.

The maverick United Mine Workers, with its welfare fund already in the bag, is far out in front of most CIO or AFL unions. But it has no immediate intention, say its

spokesmen, of revolutionizing medical practice in the mining areas. It's planning no hospitals, clinics, or salaried medical staffs. What it wants is care for its members in the quickest way available — *e.g.*, through arrangements with existing hospitals and private physicians. Current group policies of local mine-worker unions will be gradually superseded by contracts of the parent union.

Dr. James McVay, chairman of the AMA Council on Medical Service, has specifically endorsed both the UMW and ILGWU programs. Further, he feels that union medical plans in general are avoiding the features that the AMA criticizes in nationalized medicine.

"We are interested," says Dr. McVay, "in encouraging any program that will provide a high standard of service to the patient, safeguard the traditional patient-doctor relationship, and meet the other requirements of the AMA. Thus far, our study of the various plans established under collective bargaining leads us to believe that they are functioning satisfactorily in all respects."

All the signs point to rapid growth of labor's plans this year and next. The CIO-dominated, mass-production industries—steel, auto, rubber, electrical manufacturing, and others—are the likeliest candidates. They employ most of the more than 10 million organized workers not yet covered by union medical plans. —EDWARD E. RYAN

**"Now this is the genupectoral position. Ain't it a dilly?"**

*Medical societies perfect systems for round-the-clock handling of emergency work*

# Quick Action for Rush Calls

● One morning in the pre-dawn hours, a young woman in a midwest town went suddenly into premature labor. It couldn't have happened at a worse time. Her family physician was out of town and the only other doctor she knew was on vacation. In a panic, she reached for the telephone, blurted her troubles to the emergency bureau of the local medical society. There were a few clicks, then an M. D. was on the line, soothing her fears and directing her to a nearby hospital. He was there waiting when she arrived.

### *Bureaus Boom*

They may not always operate at quite such speed, but many medical society emergency-aid systems do mesh with uncommon smoothness. It's the kind of efficiency that comes from planning and hard work. Many unforeseen but important factors crop up in taking care of rush calls.

Detroit's county medical society, for example, finds that most emergencies fall on Wednesday, Thursday, and Sunday; more than two-thirds occur at night. Contrary to general belief, accidents don't usually motivate the call. Colds, flu, and heart attack are the most common complaints.

Last year the number of societies with formal arrangements for handling emergency and night calls jumped from less than sixty to more than 120. Dozens of others are in the process of setting up systems.

Getting enough volunteers for emergency duty is the first and usually the easiest step. The Medical Society of the District of Columbia reports that 75 per cent of its emergency calls are handled by

general practitioners. The other 25 per cent are requests for ambulance pickup or the services of specialists.

One problem is rotating doctors' names so that no one man is called on to do more than his share. In small communities a simple card file does the trick; the M. D. whose name is on top gets the night's calls. In larger communities, doctors are usually classified by geographic area, type of practice, etc. The Indianapolis society keeps four separate lists, one for each quadrant of the town; but it's almost impossible, it reports, to distribute the calls evenly among doctors in different sections. Those in densely populated areas are bound to have more calls.

### *Doctors on Deck*

San Francisco divides its roster into those who will accept night calls and those consenting to 'daytime emergency calls only. The Oklahoma County Medical Society uses a rotating day-list, so that physicians on emergency service won't have to hold themselves constantly available. Four different doctors are subject to call in any one 24-hour period. Their names are posted well in advance and the doctors are personally notified. A physician is rarely required to serve more than once in three weeks.

Despite good intentions, emergency-service systems sometimes misfire because of confusion in contact or follow-up methods. The Milwaukee society recognizes, for example, that to the caller in distress nothing is more unnerving than a long busy signal. It has installed eleven trunk lines in its telephone exchange, so that no one receives a busy buzz for more than a few seconds.

For ease of contact, it's also essential to have full information on each doctor volunteering for emergency service—not only his home address and phone number, but also his hospital affiliations, clubs, and lodges.

Most societies work in close cooperation with the police and fire departments. San Diego's Doctors' Service Bureau maintains a direct line to the police station. When an emergency is picked up by a police ambulance, the bureau checks to find which hospital has room for the patient. In Toledo, the city health department has a direct extension to the medical academy; nights and week-ends the academy handles reports of contagion, requests for special serums, and other public health contingencies

Once a request for help has been received and registered, an emergency service must relay it quickly. In general, there's less risk of a snag if the service itself phones the physician than if it furnishes a name and number to the caller. People have been known to make no effort to contact the doctor, yet later complain that medical care was denied them. Pennsylvania's Dauphin County Medical Society (Harrisburg) asks callers to *re-*

*main at the phone* until the operator calls back to say that a doctor is on the way. Michigan's Wayne County Medical Society (Detroit) has the doctor phone the patient before he starts out.

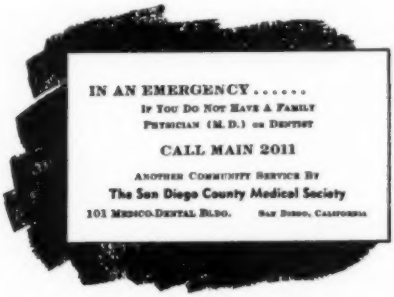
When the physician himself makes this telephone follow-up, he can not only give advance instructions, if necessary, but can also check on the urgency of the call. Some societies feel that all requests for emergency aid should be treated as urgent, with no attempt at screening. Others, particularly in more heavily populated areas, consider a certain amount of sifting desirable. But they stress that this should be done by the doctors, not by the switchboard girls.

The switchboard of the Academy of Medicine of Toledo and Lucas County has a conference-call mechanism enabling the operator to make a three-way connection between herself, the caller, and any physician in the city. Then the operator, listening in, can act as the doctor's assistant in arranging for ambulance service or hospitalization. The Erie, Pa., society posts a doctor on its night exchange. He personally routes each emergency call. This duty is handled mostly by young doctors and new members of the society.

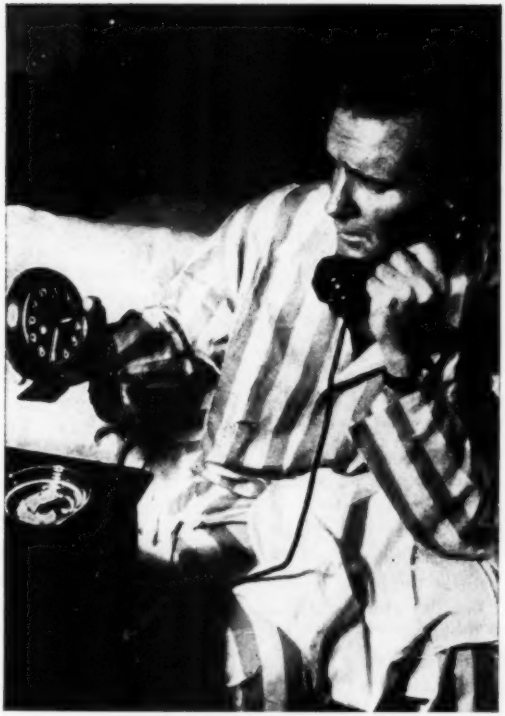
There's little doubt that a top-notch emergency service builds excellent public relations. Newspaper notices, placards, and classified phone directory ads, paid for by the societies, inform people that emergency care is always available.

How does the individual doctor fare when collection time rolls around? From all reports, the rate of collections for emergency services is surprisingly high. Service users in Erie, Pa., and Washington, D. C., for example, make good in 95 per cent of all cases.

Poor collections are apt to be less a result of patients' unwillingness or inability to pay than failure to




**This card has been widely distributed in San Diego's hotels and homes.**



understand that they are expected to. To counteract this, many medical societies tactfully publicize the fact that the emergency service is manned by private physicians. Patients are cued to call their family doctors first. If a caller says he has none, the operator asks whether he wants a private or a city physician.

Some societies go one step further and push the idea that all families, particularly those with very young children, should have a regular physician for all calls.

To better its service, the Wayne County Medical Society keeps a complete record of every emergency case covered, writes each patient a follow-up letter asking for comment. Like many another society, it reports a steady increase in the number of requests for emergency aid. Detailed records plus public comment are showing the way toward improvement all the time.

—MARTIN KEELER

# A Rural Health Program That Works

***How one state society is meeting the need for better medical care in farm areas***

● One day last spring a well-spoken, prosperous-looking country doctor gave a talk before a group of medical-school seniors at the University of Michigan. His recitation of the satisfactions of general practice in rural areas must have sounded revolutionary to a bunch of youngsters reared to venerate the urban specialist as the living symbol of success. But the visiting M.D.'s message hit home:

That June the university hospital had thirty applications for its eight G.P. interneships. The men it finally selected were the eight highest in the class.

The country doctor's talk was no accident, no one-man crusade. It was part of a carefully laid campaign in which general practitioners from rural counties visited and spoke at every medical school in the state. This visiting-speaker campaign was, in turn, merely part of a larger program to bring better medical care to Michigan's farm regions.

Though only two years old, the physician-sponsored program has already begun to bear fruit. Today in Michigan there are more medical students seriously interested in general practice, more young G.P.'s setting up in rural areas, than ever before. More state money is available for medical education; more lay organizations have rallied to the side of medicine. Many more people throughout the farming areas of the state are enrolled in Blue Cross and Blue Shield.

### *Six-Doctor Start*

It all grew out of an AMA rural health conference early in 1947. A half-dozen physicians attending from Michigan decided it was just the sort of get-together needed in their own state. Back home, they put it up to the state society, which promptly gave them $2,000 for a state conference.

Nine months later, the meeting was held. The society had lined up twenty-eight lay organizations as co-sponsors. A few score representatives were expected. Yet actually over 300 people turned up, representing seventy-eight organizations.

The gathering buckled down to business, four days later had these results to show:

¶ Approval of "The Michigan

Foundation for Medical and Health Education," to advance loans to medical students who agreed to enter rural practice.

¶ Creation of a physician placement service, under auspices of the state society.

¶ A plan for a nurse recruitment program.

¶ A plan for more local community health councils.

¶ A plan for another state conference the following year.

The education foundation, now getting into full operation, solicits funds from lay organizations, wealthy citizens, and all other likely sources. By early this year it had $100,000 in the till. Its first scholarship loans will probably be awarded this fall. Recipients must agree to practice in a rural section of Michigan for a stipulated period after graduation.

### *Location Guidepost*

The placement service operates as a clearinghouse both for doctors in search of rural practices and for small towns in search of doctors. It supplies complete economic, population, medical-facility, and other data on any area, helps the interested physician pick a suitable spot. To any town inquiring for a doctor, it furnishes a list of M.D.'s worth approaching.

Says Dr. John S. DeTar, speaker of the Michigan State Medical Society's house of delegates: "We have no precise statistics on how many M.D.'s have settled in rural areas as a result of this service. But the number is substantial."

To spur the nurse recruitment drive, the society enlisted the help of its women's auxiliary. It also set up, within the society, a commission to investigate not only the need for nurses in rural areas, but also for physicians' associates, dietitians, physical therapists, X-ray technicians, and twenty-one other categories of medical workers. So far the society has spent $8,000 on the survey and recruitment campaign. It has distributed some 25,000 brochures among 4-H clubs, schools, and other organizations.

### *Home-Town Touch*

An important phase of the Michigan campaign is its stimulation of local communities to grapple with their own special problems. Dr. DeTar, himself a rural G.P. of long experience, believes that local action on rural health far outweighs that on the state or national level. "Until the rural people—the farmers, laborers, village doctors, and civic leaders—are aware of the need for cooperative action among themselves," he says, "no national or state action can possibly fulfill its purpose."

The state society's first step toward rousing local interest was the formation of a "Michigan State Health Council." Membership includes all state organizations interested in health promotion work. This year will be the council's first full year in operation; its expenses

for the period are estimated at $22,500. This sum has already been voted by the society and by the state's Blue Cross and Blue Shield plans.

Early in the year the council hired a full-time executive secretary and set up an office. The secretary's main job is to help local communities form health councils of their own.

A number of communities have already moved into action. One rural center, for instance, formed a health council months ago, lost no time in laying plans for a community health center. Now nearing completion, it will have offices for a doctor, a dentist, and a county nurse. The cost: about $15,000.

The state council also is rounding out a survey of rural health. "Up to now, we've been shooting blindfold," says Dr. DeTar. "What this study will tell us is just what facilities and personnel are needed where, and how much rural people can afford toward health centers, health insurance, and so on." The study, made in cooperation with Michigan State College, is based on interviews with about 1,000 rural families at a cost of more than $12,000. Findings are now being compiled.

Community enrollment drives in prepayment plans have been dovetailed with the state society's rural health program. Two years ago the society induced both Blue Cross

**"You can't sleep? That's funny; neither can I."**

and Blue Shield to permit individual enrollment in community campaigns. Since then, twenty-five communities have been covered; twenty more are on the waiting list. Blue Cross and Blue Shield each now claim about one-quarter of the state's population, with heavy representation from farm regions.

### *Doctors Step Down*

The state's second annual health conference met last fall. Probably its most noteworthy feature was the marked gain in lay interest.

"Our big mistake at the first conference," says Dr. DeTar, "was allowing physicians to dominate the gathering. This time we expanded our list of co-sponsors from twenty-eight to forty-one lay organizations. We got more farm leaders and other laymen to chairman discussion panels. We broke the conference down into sixteen discussion groups, encouraged everybody to speak his piece.

"We doctors are getting ready to step down now and turn initiative over to the lay people. Most active and helpful organizations have been the American Legion, the Farm Bureau, the Michigan Society for Crippled Children and Adults, and our state rural paper, the Michigan Farmer."

The public education phase of Michigan's rural health program has leaned heavily on radio. Twenty-six local stations, plus commercial sponsors, have donated $240,000 worth of air time. The state society has spent $46,000 on the preparation of some 13,000 broadcasts. Another $15,000 has gone into a movie, which has been shown in over 400 theaters. Many other states have borrowed the film.

To finance its program, the Michigan State Medical Society has assessed its members $25 apiece for each of the past three years. Part of the kitty, however, has gone for general public relations activity, over and above the rural health drive.

The end result of it all? It's still too early, Dr. DeTar feels, to measure tangible gains. In general, the state society is seeking to correct six conditions in Michigan's rural areas: (1) high incidence of disease and accidents; (2) faulty nutrition; (3) inadequate immunization; (4) too few hospitals and doctors; (5) low level of health education; and (6) skimpy protection against the economic shock of sickness.

### *Blissful Ignorance*

These are the sore spots suggested by preliminary findings of the health survey. Though detailed findings are not yet available, Dr. DeTar points to one eye-opening discovery: 70 per cent of the people interviewed had never heard of socialized medicine.

"Whether they soon will," he says, "depends not only on the success of what we're attempting here, but on aroused action everywhere else on this business of rural health." —E. K. BUCHANAN

# You and the Alcoholic Patient

***Some cues for the practicing M. D. on latest developments in AA and similar movements***

● Of the 55 million drinkers in the U.S. today, some 3 million are chronic alcoholics—men and women whose passion for the bottle seriously interferes with their physical, economic, and social well-being. Some wind up in the drunk tanks of the city jails, some in the psychopathic wards of mental hospitals. Others may be sitting right now in the waiting room of your office.

No one needs stacks of statistics to get the lowdown on America's drinking spree. Even the most remote agencies have felt its impact. Not long ago, for example, The Gideons noticed that the Bibles they placed in hotel rooms throughout the country were becoming somewhat the worse for wear: Too many traveling men liked a combination of gin and the Scriptures. At the Stevens Hotel in Chicago, The Gideons promptly installed their own antidote: Bibles with alcohol-proof covers.

That takes care of the Bibles—but what about the men? The question is as much of a stickler for physicians as for anyone else. Contrary to public belief, many alcoholics seek private medical advice. A recent survey of New Jersey doctors showed that 65 per cent treated some cases of alcoholism each year (the average was about seven cases per doctor). But most physicians were frank in stating that they considered these cases a nuisance. The alcoholic, they pointed out, is prone to resist or resent treatment. He may call up from the corner pub for a chat at 2 or 3 A.M. Nor is he exactly a good risk as a bill-payer.

### *A Handful of Outs*

In trying to help the alcoholic patient, the G.P. usually has a five-way choice. He may treat the immediate physical disturbances and let it go at that. He may try to come to grips with the underlying emotional disorders. He may refer the patient to a psychiatrist. He may suggest an alcoholic sanitarium, such as the Keeley Institue. Or—often his best bet—he may seek aid from one of the many agencies springing up to help doctors cope with alcoholics.

First on the list is Alcoholics Anonymous, still the mainstay of

alcoholic rehabilitation in the U.S. Comments one medical pundit: "They're about as anonymous as the New York Yankees." Everybody knows about this stalwart organization, founded fifteen years ago by a Manhattan stockbroker and an Akron physician. In the last few years it has more than doubled its membership, from 35,000 to over 75,000.

AA stands ready and willing to help all alcoholics who show signs of wanting to recover. "We welcome the janitor who sweeps out an office," says an AA spokesman, "just as much as the vice-president who gets swept out." About 50 per cent of the membership never drinks again. Another 25 per cent makes the grade after a couple of lapses.

Says Dr. Milton G. Potter, chairman of the New York State Medical Society's committee on problems of alcoholism: "No rehabilitation program can progress very far without the active cooperation of Alcoholics Anonymous. After the acute phase of this disease has passed, the care of the alcoholic is more an art in the hands of the understanding person than a science wielded by trained technicians."

### *Lush Treatment*

AA members, like most students of alcoholism, feel they could do much better if special facilities for the care of alcoholics were expanded. Although some private institutions have top-notch reputations, the cost of these places—up to $30 or more a day—is prohibitive for the average liquor addict. Mental hospitals care for only a small percentage of cases, since they are obliged to limit themselves to the psychopathic problem drinker. The non-psychotic alcoholic, who is in the majority, finds few institutions that will try to put him on his feet.

### *How AA Helps*

AA now has worked out an arrangement with New York's Knickerbocker Hospital. Under it, the hospital reserves several beds for the exclusive use of alcoholics. In return, AA agrees to recommend for admission only those patients with a sincere wish to recover. It also agrees to place members on duty as orderlies, to help care for the patients. The Knickerbocker plan includes a program for continued assistance after the patient is released. During this phase, the hospital staff and AA members work closely with families, employers, friends, and social service groups.

Another agency out to see that the alcoholic gets a break is the Yale Plan on Alcoholism. This organization runs one of the most ambitious research, prevention, and rehabilitation programs in the country. The project was established in 1943. The following year it opened two public clinics in Connecticut. Recently the Yale body

set up a research unit at Texas Christian University and a clinic at Dallas for alcoholic rehabilitation. Yale Plan clinics give diagnostic and consultation services. Institutional care is suggested only in extreme cases.

Another Yale Plan innovation is a consultant service for industry. The aim here is to alert business to alcoholism as a major industrial problem—one that costs it 30 million man-days per year. There is a growing tendency for doctors and businessmen to get together on this matter. Last year the first industrial conference on alcoholism was held in Chicago, under the chairmanship of Dr. Anton J. Carlson.

### *Educating the Public*

The Yale Plan's longest-reaching educational arm is the National Committee for Education on Alcoholism. NCEA urges physicians who want information on facilities for alcoholic care to write its national office, 2 East 103rd Street, New York City.

A hopeful sign is that new facilities for the care of alcoholics are constantly opening. Some examples:

*University of Buffalo Rehabilitation Center.* Opened last winter, this clinic provides medical and institutional care for $10 a day.

*Bridge House.* This institution is maintained by New York City's Bureau of Alcoholic Therapy, the first municipal agency of its kind. Faced with the high cost of maintaining drunk tanks in local jails, the city decided that rehabilitation might save money. Since its founding five years ago, Bridge House has averaged 66 per cent success in curing alcoholics. It treats from 350 to 400 men a year. Average length of stay: three to four weeks.

*Stamford Clinic.* This is probably the best-known of five outpatient clinics set up by the Connecticut Commission on Alcoholism. The Stamford Clinic can handle a total of sixty-five patients a month. It treats them in pleasant surroundings, tries to get away from a grim institutional atmosphere. Those seeking aid range from unemployed dishwashers to the wife of a high-bracket department store executive. The commission's work is supported by allocation of 9 per cent of the liquor license fees taken in by the Connecticut State Liquor Control Commission.

This latter program is typical of a broad trend toward state action on alcoholism. Some forty-four state legislatures are considering or have enacted laws to provide modern medical care for alcoholics. Virginia last year appropriated $200,000 to be spent over a two-year period on treatment, rehabilitation, and research.

Best hope for the future is that people are beginning to look upon the alcoholic less as a comic character and more as a sick man. The growing tendency is to regard alcoholism as a public health problem, calling for over-all planning and action. —NELSON ADAMS


**Without textbooks, Ernest Rothe primes class for licensing examinations.**

# CRAMSTER

CLOSE UP

"Suicide is our chief hazard," says Dr. Ernest Rothe, who operates a Manhattan cram school for doctors aiming at state board exams. He adds, with pride, "I don't know of a single student of mine who's tried it, though."

The doctor's remark about suicide is no gag. His students are mostly D.P. physicians newly arrived in America. The suicide rate among such people, he explains seriously, is far above average.

Many displaced practitioners, it seems, tend to look on the examining board as the great bogey standing between them and a settled life here. Failure to pass, coming on top of all that they've been through in Europe during and since the war, is sometimes the last straw.

Says Dr. Rothe: "I concentrate almost as hard on teaching them how to flunk philosophically as I do on preparing them to pass."

But his record on the latter count is nothing to blush about. In ten years of high-speed teaching, he's put 75 to 80 per cent of his men over the board hurdle on their first try. He doesn't know how many that adds up to, in all. Nowadays classes number from twenty to thirty students. The course lasts sixteen to twenty-one weeks and he keeps it going nearly all year round.

The curriculum parallels that of the average medical school: anato-

my, physiology, chemistry, bacteriology, hygiene, surgery, obstetrics-gynecology, pathology, and diagnosis. Dr. Rothe covers these subjects successively, spending from several days to several weeks on each. He doesn't pretend to do any more than hit the high spots. Yet it's a tough regimen for the immigrant M.D.'s: classes from 4 to 9 P.M. three days a week, plus eight hours' homework daily.

Tuition for the full course is $220. But the doctor has been known to cut this substantially in special cases. Some students sit in for a brush-up on only one or two subjects, at $5 per session.

A prime difficulty for most men is the language problem. Generally they can pass the simple English examination required for a license; but they bog down when it comes to writing out lengthy answers on the technical exams. Dr. Rothe insists that everyone speak and take class notes in English, which he corrects for spelling and grammar.

"I also spend considerable time on the technique of American examinations," he says, "and on precisely what's called for when the examinee is directed to 'explain,' 'discuss,' or 'list.'"

A refugee himself, mild-mannered Ernest Rothe knows what his students are up against. He acquired his medical degree at the University of Berlin, had built up a substantial practice and reputation in psychiatry when Hitler came to power. Dr. Rothe left Germany for Holland. There he got a job as an industrial psychologist, scrimped for five years to get to America.

Arriving here in 1938, he obtained a research fellowship at New York's Mt. Sinai Hospital. Though he passed his examining board tests handily, he could see the difficulties they presented to other immigrating physicans. He had taught at the university in Berlin and possessed a natural pedagogic bent; so before long he was tutoring other refugee M.D.'s. The following year he set up his school. Now 51, he no longer sees patients, spends all his time on his classes.

The school itself, in a brownstone basement off Manhattan's West 73rd Street, falls somewhat short of academic splendor. The one and only lecture room is generally overcrowded. No textbooks are used; each student equips himself with an English dictionary, a medical dictionary, and an anatomical atlas.

Beyond that, he's dependent on his lecture notes. Dr. Rothe relies heavily on visual aids to instruction —*e.g.*, a length of four-inch hawser to demonstrate the structure of a protein molecule.

In this somewhat primitive manner, he has helped hundreds of colleagues through New York and other state boards. His cram course has also had some side values: More than one native-born physician has found the Rothe lectures just what he needed to brush up for his specialty-board exams. END

**A flair for promotion, plus efficiency techniques, have spelled success for Dr. Anson Brown and his laboratory. He has a staff of twenty-odd, but still conducts many tests himself.**

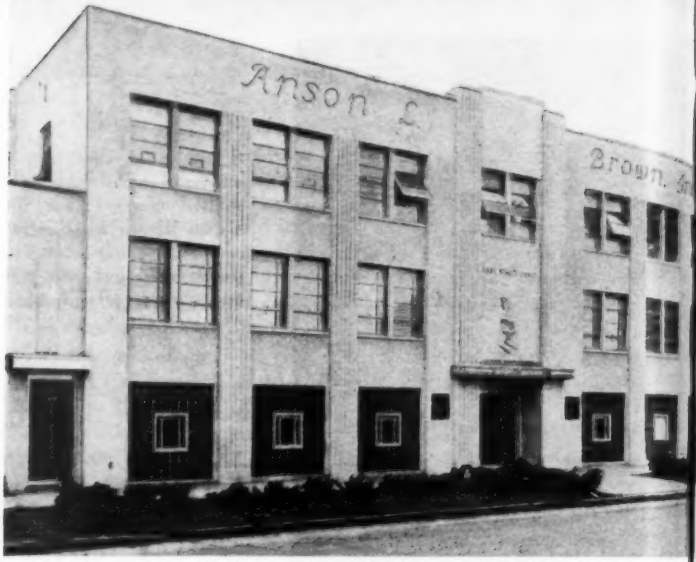
# LABMAN

CLOSE UP

"Laboratorially yours, Anson L. Brown, M.D." That signature, belonging to a dapper, dynamic doctor-businessman of Columbus, Ohio, is becoming known to more physicians each year. As founder-chief of one of the nation's busiest commercial laboratories, Dr. Brown handles about half a million clinical tests annually for some 4,000 M.D.'s. He has clients scattered all over the United States.

At 56, Anson Brown still exudes all the drive and zest it took to build a flourishing organization from scratch. In the quarter-century he has devoted to lab work, he has made a professional trademark of assembly-line techniques and big-business promotion methods.

But the doctor is more than a shrewd business executive; he's a dedicated clinical pathologist, convinced that lab tests and still more lab tests are the most valuable tool of medical diagnosis. To hammer home his point with colleagues, he's coined slogans (*e.g.*, "Diagnosis by Laboratory"), authored books, addressed medical societies, and turned out enough pamphlets to




**$300,000 laboratory was designed by doctor-owner.**

make it worthwhile to set up his own printing shop.

Solid proof that his campaign has paid off is a new white limestone building he recently built to house his laboratory enterprise. The thirty-three-room structure combines scientific functionalism and Hollywood glamour.

Some three dozen employes work in air-conditioned, pastel-tinted laboratories, with canaries twittering in the background. Soft, recorded music is piped all day through a public address system.

Says the doctor: "There's no reason why a laboratory should be cluttered and dingy." His passion for perfection drives him to devote as much care to the selection of office draperies as to the development of a new test for pregnancy.

He is unabashedly proud of his laboratory and identifies it with himself at every turn. "Anson L. Brown, Inc." is graven in two-foot letters across the building's facade. In the lobby hangs a vast oil painting depicting the evolution of the microscope, from the days of inventor Antonj van Leeuwenhoek (in the background) to the times of Anson Brown (upstage center).

All this personal publicity is, of course, an essential part of the Brown promotion campaign. "Advertising," he says, "is ethical and right when directed from one doc-

tor to another, since the recipient can evaluate the proffered services. This sets it apart from appeals to the public, of which I do not approve."

Besides master-minding his laboratory's business policies, Dr. Brown supervises its scientific work. He is usually at his desk by 8 A.M., greeting his staff with such explosive pleasantries as, "How the hell are you today?" or "What's the state of your gizzard this morning?" He somehow manages to be everywhere at once, in response to constant paging over the building's public address system. "The boss has so much energy," says one of his staff, "that it makes the average person tired just to watch him."

Dr. Brown does all the differential blood counts himself. In addition to his lab activities, he teaches classes in the technicians' school that is an integral part of his establishment. The school offers courses of three, six, and twelve months' duration. It averages an enrollment of fifty students. Its principal textbook was written by Anson Brown.

Before entering Ohio State's medical school, he spent eight years in the laboratories of assorted industrial firms. It was here that he saw in commercial lab operation a wide-open field for the enterprising physician. "Doctors," he confides, "would rather deal with doctors." A year before taking his M.D., in 1927, he launched his laboratory

**Brahms symphonies accompany laboratory blood tests.**

venture. While still in medical school, he solicited patronage among Columbus medical men, door to door. The business grew steadily, got its biggest boost in 1941 when Ohio passed its premarital blood test law.

Another lift came four years later, when prenatal serologies became a legal requirement of the state. It was about this time that Dr. Brown began shaping plans for his present layout.

In the process of expanding, the doctor has perfected a pattern of service that he feels most closely meets the needs of physicians. This includes a local pick-up service, specimen drop-boxes outside the building, night emergency service, fast handling of mail orders, and special low rates for group tests.

For a number of local physicians, the Brown laboratory runs off a special set of tests on each patient requesting a periodic check-up. The tests include blood sugar, N.P.N., cholesterol, differential blood count, Kahn, Kline, and Mazzini procedures. The cost: $3.50 per patient. The laboratory makes no charge for charity cases.

To further enlarge the scope of Anson Brown, Inc., its enterprising director is busily turning out new brochures, further streamlining the operations of his laboratory. "There is never any end," the doctor says confidently. "There are only beginnings." END


**"I've been sick to my stomach a lot lately, Doctor —ulcers, I hope."**

# Report From Britain

## What the medical profession thinks of the National Health Service

• Most people in Britain will tell you that their state medical service is "jolly good." Most doctors are less enthusiastic.

Yet you can't gauge professional reaction to the scheme merely by asking, "Are you for it or against it?" The typical practitioner likes some things about the scheme and dislikes others. Your only solution is to measure his likes against his dislikes and find out which bulk the larger.

This was done in the course of the present study. It showed that the weight of opinion among three-fifths of the doctors interviewed was against the National Health Service. About one-fifth of the physicians were, by and large, for the scheme, and the rest were on the fence.

Judged by American standards, Britain has always had more than its share of poverty. Up until July 1948, literally millions of indigent and near-indigent got only the barest medical attention. Some got none. British doctors now agree, therefore, that *some* tax-supported plan *had* to be launched to put treatment within reach of these people. The tremendous advantage of the National Health Service, they feel, is that *medical care can now be given the patient without regard to financial considerations.*

"To the established doctor, the scheme offers no advantage whatever," said a G.P. in Kent. "But it's a great thing for many patients.

"We can now do so much more for the poor patient especially. We can visit him as often as needed without feeling that we are running up a big bill. We can order what's best for his condition without worrying whether he can pay for it."

A young orthopedist in Manchester said, "There is no doubt that a large number of the poorer members of the nation are receiving better medical care than they did. They are certainly receiving spectacles properly prescribed for them. They are also getting proper surgical appliances.

"It may of course be argued that in the present economic state of the

country the expenditure being made for such things is unwise. And it is evident that most of the patients supplied with appliances will not thereby be made more fit for productive work. Nevertheless, the service has uncovered a very real need for medical care; and a great many cases are now receiving attention that was long overdue.

A. G.P. in a village not far from Liverpool said, "My personal inclination would be to scrap the NHS in its entirety. But for the benefit of my patients I'd keep it. The scheme is doing its greatest good in the industrial and lower-class areas."

---

Faced with the possibility of a medical new deal in the United States, American physicians want whatever cues they can get from the state medical scheme in Britain. To gather such cues first hand, the editor of MEDICAL ECONOMICS recently undertook a month-long, 2,000-mile tour through England, Wales, and Scotland, visiting every principal city there and as many small towns.

Mr. Richardson's aim was an objective study that would show how British doctors and patients are being affected by state medicine and what they think of it. The results of the study are being presented in a series of articles, of which this is the third.

The author was aided in his inquiry by the opinion research firm, Mass-Observation, and by MEDICAL ECONOMICS' British correspondents, Harry Cooper & Staff. More than 300 depth interviews were conducted among doctors and patients and among the heads of the various professional associations and the Ministry of Health.

Medical men to be interviewed were chosen at random by taking every *n*th name in the British medical directory. A sample was sought in this way that would reflect no over-all bias either for or against the Government health service. Equal care was taken to get an unprejudiced sample among the public. Here a stratified selection was made according to age, sex, location, financial status, and occupation.

Mr. Richardson's initial material is being kept up to date as follow-up reports are received each month from London.

Another G.P., in Dundee, Scotland, felt the same way: "There's a lot of things wrong with the health service. But at least for the poor people some such arrangement is necessary.

"Doctors have always served the poor gratis. But it was not properly their responsibility. Now the cost of treating the poor is a charge on society as a whole—which it should have been long ago."

### *'Limit Plan to Poor'*

While Britain's doctors agree that a better plan of medical care for the poor was imperative, many deplore what one called "its extension to persons of substance." An income limit, they feel, should have been imposed on those who were to get free medical attention; the self-supporting should have continued to pay their own way.

Among the several good points alleged for the National Health Service is its payment of a living wage to specialty trainees. Another popular feature is the Government's $1,200-a-year basic salary, paid under certain conditions to G.P.'s whose lists of NHS patients aren't large enough to support them—*e.g.*, young men starting practice and old men tapering off.

Although the price of these handouts is an eventual loss of personal freedom, many young doctors have jumped at the bait. With economic conditions in Britain getting worse all the time, the Minister of Health reasoned that the rising generation of M.D.'s would rather be hooked than hungry. And he wasn't far wrong.

### *Good Points*

Another thing these beginners in medicine like is that they no longer have to buy a practice in order to get started. Instead of plunging themselves into debt to the tune of, say, $10,000 to purchase a practice (and being saddled with repayments for years thereafter), they now simply nail up their "plates" and go to work. There are usually plenty of patients to go around; and if there aren't, the Government's basic salary can be applied for.

A young G.P. in Cheshire, demobilized from the RAF last November, said, "The National Health Service may well prove to be an example of impractical idealism. But it has saved me from having to buy a share of a practice, which means a load of financial worry off my mind. To that extent at least, it has indeed been a blessing."

Established practitioners, when asked what they like about the NHS, mention several minor points, such as "There is no dispensing of medicines" and "There are no bills to bother about." But a major factor with some has been the pay:

Take the case of a G.P. in one of Britain's crowded, lower-class industrial districts. Before July 1948 perhaps half his practice was made up of employed panel patients—

[*Continued on* 146]

# If You're Thinking of Retiring

***Here's some advice from out-of-harness M.D.'s to colleagues still in practice***

● You can't start too early to get ready for retirement. That's the opinion of the average physician who has already retired. Among a sizable group surveyed by this magazine, less than 40 per cent say they have found reasonable contentment in pasture. And these men have made a success of retirement only because, as a rule, they began preparing for it years in advance.

"Take time out *now* to develop hobbies—at least one of them sedentary," counsels a Mississippi physician who quit practice nine years ago. "The toughest years of my life were the three or four immediately following my retirement. I've since made some adjustments, but it's hard to cultivate new interests in later life."

Retired M.D.'s seem to fall into three major categories: (1) fully contented, enjoying themselves; (2) nervous out of service, not finding much fun in life; and (3) downright miserable. The latter group, roughly one-quarter of the total, consists mostly of men forced out of active practice by broken health.

The other three-quarters are about evenly divided between groups 1 and 2. Their activities in retirement are usually a tip-off to their state of mind. Consider these sample activities reported by the not-quite-happy M.D.'s:

¶ Reading, keeping house.

¶ Very limited activities; grow some flowers and fruit.

¶ Listening to the radio.

¶ Tending house, lawn, and garden.

Contrast those with the following reports from fully-contented physicians:

¶ Water-color painting, machine-shop work, trailer-touring the country. I'm a busy guy.

¶ Gardening, carpentry, bricklaying, sailing, automobiling, bridge, reading, walking, gossiping—a wonderful new world!

¶ Conduct physical exams for local mine; serve as part-time county health officer. Am golf-club president, secretary of rodeo association, director of sportsman's club.

¶ Always wanted to write; since retirement, have published two volumes on Creole folklore that have been well received.

¶ Following up life-long interest in paleontology. Am now studying

the magnificent Great Middle Triassic Fossil Field in Nevada.

Money is important, of course—up to a point. Those who are strapped bemoan the fact. They advise taking out plenty of retirement insurance early. Yet some doctors who are getting the most out of retirement depend largely on investments and business interests that require continuing personal attention. This in itself can be one of the most satisfactory of hobbies.

In virtually every case, these interests were acquired *before* retirement. In some instances, the doctor's abandonment of practice was gradual, with outside activities taking up more and more of his time. These men have found separation from medicine nothing like the wrench it's been for many others.

What's best about getting out from under a busy practice? Pretty much what you'd expect—but with a surprise twist here and there. Most frequently mentioned blessings are adequate rest, liberation from the tyranny of the telephone, a full night's sleep, getting to know and appreciate your family, doing as you please, freedom from nerve strain, and not having to listen to other people's troubles.

The other side of the coin—"What do you like least about retirement?"—brings a still wider variety of answers. For instance:

"That on-the-shelf feeling."

"Lack of glamour and limelight."

"Showing my old age."

"Having to move 150 miles away

## Billboard Medicine

• The adman's world is populated by persons not sick enough to visit a doctor but sick enough to be unhappy. They are prey to a group of benign but anti-social syndromes for which self-medication has become the rule.

The advertised ailment is pictured more often than not as the root of sexual rejection. If a girl cannot tolerate a boy, this is attributable to his complexion, his breath, or his bowel schedule. He has merely to consult the index medicus of his favorite magazine and mail 10 cents in stamps or coin for a generous sample of the formula for the better life.

The diseases described in the ads are in the realm of poetry: They cannot be defined, but they are recognizable every time. Since the medical encyclopedias do not include discussions of these afflictions, and since the morbidity rate must be high, it would be well for us to study them.

The first group of symptoms has to do with lack of *zest*. The ad- [*Continued on* 163]

from friends who otherwise would not permit me to retire."

What's the logical quitting age? Among those surveyed, the average was 64 but the range was wide. Excluding those laid low by illness, the earliest retirement age was 40, the latest 85. Those who are happiest with their present lot were also apparently most eager to achieve it. They retired at age 62, on average. Their somewhat more doleful brethren held off until 66. Among the handful of acutely unhappy men, the average retirement age was 75.

None of the retired M.D.'s seem to think there is an optimum age for taking the plunge. A number say they'd quit at least five years earlier if they had it to do over again.

Several others advise: "Work till you drop in harness." Only one man in the entire list is seriously considering returning to practice.

"Retire when you can," says a retired midwestern M.D., "but only to work at something else you really love." A Florida physician writes: "When my work began to tire me and I no longer cared to see a patient come into my office, that's when I called it a day."

Another man advises: "Retire to some spot where you have old friends and acquaintances, preferably in a mild climate." And a former G.P., now rather at loose ends, says: "Doing it over, I'd spend a few years in some specialty, take in a young partner, then retire to office work only."

Even if it's tough going at first, that doesn't necessarily mean you're doomed to unhappiness in retirement. One 75-year-old doctor, out of practice ten years, sums things up this way: "In the beginning I spent most of my time feeling sorry for myself. Nothing to do, not enough money to do it with. Then I rounded up some other fellows in the same boat. We got to fishing and playing cards together. Now the days aren't long enough for all I want to crowd into them. I've learned how to become rich without increasing my income."

—HENRY O. PETRY

## As Handsome Does

● The doctor completed his examination of the patient and asked him to wait in the waiting room. He called in the man's wife for a confidential word on the case. "Madam," he began bluntly, "I don't like the looks of your husband."

"Neither do I, Doctor," was her apologetic reply, "but he's so good to our children."

—LESTER V. SALINSKY, M.D

# Here Lies . . .

● A favorite form of epitaph in times past was the amateur autopsy report. Witness these authentic examples:

From a grave marker in Medway, Mass.:

BENEATH THIS STONE, A LUMP OF CLAY,
LIES UNCLE PETER DANIELS,
WHO TOO EARLY IN THE MONTH OF MAY
TOOK OFF HIS WINTER FLANNELS.

From an Enfield, Conn., headstone:

*Here lies cut down like unripe fruit,*
*The wife of Deacon Amos Shute:*
*She died of drinking too much coffee,*
*Anny Dominy eighteen forty.*

From a graveyard in West Tisbury, Mass.:

*John Ferguson*
*d. 1787*
*aged 11 years*

THE OIL OF VITRIOL HE DID TASTE
WHICH CAUSED HIS VITALS FOR TO WASTE
AND FORCED HIM TO RETURN AGAIN
UNTO THE EARTH FROM WHICH HE CAME

From a headstone in Burlington, Mass.

*Here lies the body of Mary Ann Lowder;*
*She burst whilst drinking a seidlitz powder;*
*Called from this world to her heavenly rest,*
*She should have watted until it effervesced.*

—WEBB B. GARRISON

# Making a Prepay Plan Click

***How one physician-backed plan got off to a late start, then set enrollment records***

● The day had come. The country's newest medical care plan was to start paying claims. Newsmen and photographers, all set to feature Connecticut Medical Service's first beneficiary, jammed the plan's New Haven offices.

Presently the initial claim arrived. The group waited eagerly as a plan official tore open the envelope.

A moment's silence. Then the embarrassed announcement: "It would seem, gentlemen, that our first beneficiary has had himself, absolutely free, an adult circumcision."

The next claim proved more photogenic, and the papers duly blazoned the fact that Alfred J. Woloszczuk of Glastonbury had received an emergency appendectomy free of direct cost one day after paying his first month's premium (75 cents). Since then, Connecticut Medical Service has been riding high.

Operative since April 1, the plan corralled 70,000 subscribers in its first sixty days. A month ago Nutmeg Staters were still signing up at a rate close to 1,000 a day. While this precedent-shattering enrollment rate probably won't last, plan officials figure that by the year's end they'll easily reach 150,000 subscribers, or twice their original goal. In a state of only 2 million people, that's a big first-year dent.

### *The Doctors Disagreed*

The Connecticut success reflects the popular demand for 1949-model health insurance. It also helps wipe out a less enviable record of ten years' shilly-shallying before the state's medical men could get together on any plan at all. The one now adopted is almost a dead ringer for the service-type scheme originally suggested and discarded back in 1939. But town and country couldn't come to terms.

But once state and county societies settled their differences, about a year ago, things began to pop. A committee of county medical men whipped the plan into shape, got the state House of Delegates' nod in December.

A month later the proposal was through the insurance commissioner's office. By February, salesmen

were out lapel-grabbing the citizenry.

It's not unlikely that the better-informed among the populace were good and ready to sign up, having had some inkling of similar medical plans in forty-four other states. Nevertheless, credit is due for a smart campaign. Smartest maneuver of all: enlisting the wholehearted support of Blue Cross.

For a solid year, a Connecticut Blue Cross staff man gave all his time to studying medical care plans in other states and to nursing Connecticut Medical Service into being. Blue Cross prepared and paid for all promotional literature. Its sixteen salesmen, sole agents for the medical plan, plugged it for months before it went on the market. For ninety days this spring, they didn't write a single hospitalization contract, concentrated instead on putting over the doctors' plan. CMS got all these services free.

Says Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society and acting medical director of CMS: "It would have been impossible for us to start this job without Blue Cross."

Blue Cross people say the plan all but sells itself. In promotion they play up these key features:

¶ No physical exams are required before a person can subscribe, and there are no age limits.

¶ The insurance is good anywhere in the world, with free choice of M.D.

¶ Full-service benefits are available to all subscribers whose family incomes are below $3,500—51 per cent of the state's population.

¶ Doctors are paid directly by the plan, with no red tape for patients.

Nearly 90 per cent of the state's 1,500 eligible physicians have signed on to provide service under the plan. The fee schedule compares favorably with those in other well-to-do states. Sample fees: $100 for an appendectomy, $65 for a hemorrhoidectomy. Cost to the patient is 75 cents a month for a single subscriber, $2.25 a month for family coverage.

Reflecting the current trend in prepay-plan management, Connecticut Medical Service has six doctors and six laymen on its governing board. The physicians are appointed by the state medical society, the laymen by Blue Cross. Dr. Barker attributes a big part of the plan's early success and bright future to the joint medical-lay management. —C. G. BENSON

# Academy Offers Health Law Blueprint

***Would scrap Wagner plan, merge 'best parts' of Hill, Taft, and Flanders bills***

● At the New York Academy of Medicine it has been our desire, like yours, to find the best means of bringing the benefits of preventive and curative medicine to all the people of our country. We are not interested in maintaining the status quo, and we are prepared to consider any changes in medical services and payment which may be better for the people.

We are cognizant of the many lacks in medical care that now exist. We agree that the health of the people is a matter of national concern, that every effort should be made to provide all our people with adequate medical care. But we feel certain that national compulsory medical insurance as proposed in the Wagner plan would result in most detrimental changes in medical practice and would harm the public. The objectives which the proponents of this bill have in mind, and which we share, can be achieved more effectively by procedures which are more orderly and far less hazardous.

National compulsory medical insurance would indeed provide the funds for medical care, wherever care is available. Probably 80 million or more people would pay in advance for home and office care; laboratory, diagnostic, and consulting services; and specialists' services. Yet, in many parts of our country, such services are unavailable or inadequate. Our Government cannot collect the money in advance, then not be prepared to deliver the goods on demand.

### *Too Much Too Soon*

True, provision is made in the Wagner bill for aid to medical, dental, and nursing education; for encouragement of a better distribution of medical services; for more rapid construction of physical facilities, and so on. However, it may

---

** This article is a condensation of the recent testimony on national compulsory health insurance before the Senate Committee on Education and Labor by Dr. George Baehr, past president of the New York Academy of Medicine, which he represented before the committee.*

take a generation of effort by Federal, state, and local authorities before the required amount of medical personnel and physical facilities can be developed.

A second fundamental fault of compulsory medical insurance is that fee-for-service remuneration of physicians—a method which almost the entire profession would choose because it is more profitable—would result in a gigantic medical racket involving patients and doctors alike. The pressure of subscribers for services and the financial rewards to the physician for mere volume of services would constitute a combination of influences difficult to resist. The inevitable result would be superficial performance and disastrous deterioration in the standards and ideals of medical practice.

### *No Boost for Groups*

The alternative method of payment proposed in the bill—capitation—would be acceptable in this country only to medical practice groups. Significant changes must occur in the organization of medical practice and in the methods of payment before comprehensive services can be provided under any insurance plan, compulsory or voluntary. The bill fails to provide encouragement to physicians to organize themselves into group practice units.

The New York Academy of Medicine has proposed a much better alternative to compulsory medical insurance. This alternative would permit us to build upon the excellent structure of American medicine and extend it as rapidly as possible to all the people of the country. We have urged legislation to provide Federal grants to the states for the study of state and local needs and the development of state and local programs to correct deficiencies.

### *Nub of the Problem*

In this country, the provision of medical care has been and will always be a local responsibility, except for mental disorders, tuberculosis, and other chronic illnesses which require prolonged hospitalization. These are the responsibility of the state.

In every locality in which medical personnel and facilities are seriously deficient the reasons are ignorance, lack of financial resources, or geography. It should be the responsibility of Federal and state governments to aid in correcting local deficiencies. Different procedures will be required in rural areas than in urban centers.

To encourage the people to contribute to the support of their own local medical services, Federal and state aid will be required for local, regional, or state-wide prepayment plans. The Academy is opposed to the Wagner program because it involves precipitate changes in medical practice that would be irreversible. We would not be averse to experimentation with such a procedure in a limited geographic

area. But we prefer voluntary nonprofit medical insurance plans because they are flexible and permit initiative.

Such plans cannot be designed primarily for the indigent or medically indigent. Premiums for families on relief should be paid by government; for those temporarily unemployed, by unemployment insurance funds, as in the Hill bill. Contributions by persons gainfully employed should be proportionate to their earnings, as in the Flanders bill. Then the lowest income group could afford to subscribe.

Federal and state governments should contribute part of the operational cost of the voluntary plans out of general tax funds. This would provide financial stability to the plans during periods of business recession.

Also, premium payments should be deductible on income tax returns, as an incentive for people to subscribe. Further, prepayment plans should meet the following requirements:

¶ They should maintain standards required by Federal and state health councils.

¶ They should provide incentives to physicians to organize into medical practice groups. These can provide comprehensive medical care, preventive as well as curative, in return for capitation payments. They could also serve as a yardstick for the performance of solo practitioners.

¶ The plans should provide similar incentives to the staffs of hospitals and health centers to organize for group practice. Young physicians would learn to appreciate the financial, professional, and educational advantages of group practice. Medicine might then be gradually transformed, at least in part, to a form which could maintain high standards of service and function more efficiently and economically under prepayment plans. Changes could be initiated without sudden dislocation or a lowering of medical standards.

¶ The plans should develop regional interrelationships of medical centers and teaching hospitals to smaller institutions, local health centers, and even to individual physicians in outlying communities.

For the reasons stated, the Academy wishes to record its disapproval of the Wagner bill. It approves in principle the Hill bill, the Taft-Smith-Donnell bill, the Humphrey bill, and the Flanders bill, with res-

ervations on details of each of them.

The Hill and Taft measures are based too heavily upon a program for the indigent and the medically indigent. A medical care plan must provide for the needs of *all* people, including the indigent. A means test for eligibility to a prepayment plan is impractical and undesirable.

The Hill bill fails to provide for comprehensive medical services. Prepayment for hospital medical care is desirable as an incentive to thrift; but it has no significant influence upon the extension of medical care or upon the quality of medical services. Such limited benefit plans play no role whatever in preventive medicine; they have little influence in encouraging prompt and early recognition of disease. Yet this is rapidly becoming a matter of urgency in view of our aging population and the increasing number of diseases that can be cured when detected in an early stage.

### *The HIP Example*

We therefore recommend that provision be included for comprehensive medical services wherever they can be made available. The experience of the Health Insurance Plan of Greater New York, which provides complete medical service for a single premium payment, indicates that under these favorable circumstances only 10 per cent of medical services are for patients in hospitals.

The development of diagnostic clinics (Hill and Taft bills) as aids to early diagnosis is praiseworthy. I established such a service at Mount Sinai Hospital, New York, for persons of moderate means almost twenty years ago; it has been in successful operation on an all-inclusive flat-fee basis since that time. But support of diagnostic clinics by a prepayment plan as an *isolated* item in medical care is actuarially unsound. Diagnostic and consulting facilities can be operated with prepaid support only when they are part of a *comprehensive* medical care plan.

### *New Commission Urged*

The Flanders bill comes nearest to meeting all the Academy's requirements for a voluntary, prepaid, comprehensive medical service plan. Because its program provides for gradual development, it would not suddenly disrupt present methods of medical practice. Through encouragement of medical groups it would tend to improve and transform medical practice by an evolutionary process.

We believe that the time has arrived for a nonpartisan measure that will accomplish the objectives for which we are striving. A nonpartisan Federal commission might be established for this purpose similar to the Hoover Commission or the Goodenough or Beveridge Commissions in England. The New York Academy of Medicine stands ready to help in any way it can. —GEORGE BAEHR, M.D.

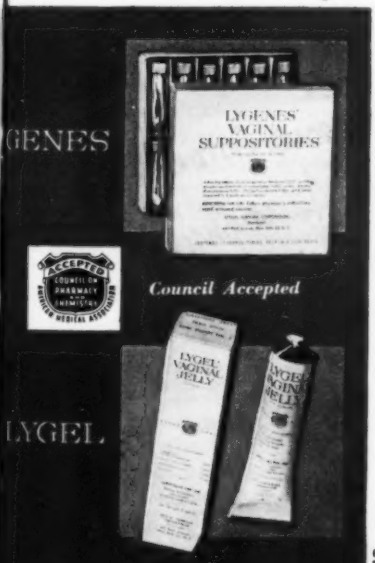
*for Contraception*

# LYGENES®
# LYGEL®

***Contraceptive Products provide clinically proved protection***

rmal function without anxiety, fear or devices—plus patient-operation.

The aim of modern contraception—to instill complete confidence—is fully realized in this line of contraceptives which provide a high degree of effectiveness. Non-toxic, esthetically acceptable, non-irritating, economical.




**LYGENES VAGINAL SUPPOSITORIES**—Clinically Proved Highly Effective. Small, non-odorous vaginal suppositories which form an adhesive, effective cervical barrier in a matter of minutes. No diaphragm or other devices required. Convenient. Facilitate patient-cooperation. Economical—in boxes of 12, foil-wrapped.

ACTIVE INGREDIENTS

*Hydroxyquinoline Benzoate 0.30%*
*p-Chloro-symm.-m-dimethylhydroxybenzene 0.05%*
*p-tert. Amylhydroxybenzene 0.05%*
*Zinc Sulfocarbolate 0.50%*
*pH 4 (when dispersed in 4 parts normal saline)*

**LYGEL VAGINAL JELLY**—A jelly of high spermicidal efficacy with freedom from irritation and ready patient-acceptance. Readily dispersible. Does not lose viscosity at body temperature. 3-oz. tubes.

ACTIVE INGREDIENTS

*p-Chloro-symm.-m-dimethylhydroxybenzene 0.05%*
*p-tert. Amylhydroxybenzene 0.05%*
*Benzalkonium Chloride 0.10%*
*Lactic Acid 0.25%*
*pH 3.4*

***Literature and clinical trial packages on request.***

**ecial Formula Corporation**

*DISTRIBUTOR*

Park Avenue, New York 22, N. Y.

Special Formula Corporation, Dept. ME
445 Park Avenue, New York 22, N. Y.

*You may send me (check your preference)*

1 Package LYGENES Suppositories ☐
1 LYGEL Refill ☐

_____ M.D.

ADDRESS _____

CITY _____ ZONE _____ STATE _____

# When You Recommend a Specialist

***If picking the right man poses a problem, here are some tried-and-true tips***

• To get some inside cues on the business of recommending a specialist to a patient, this magazine checked with a dozen veteran G.P.'s. It learned some interesting things.

Said one of the men interviewed: "In one's own community, the temptation is to select a personal friend, a classmate, a reciprocator, a fee-splitter, or the service chief at the hospital. These make up many a doctor's entire consultation team. Yet specialists should not be recommended on the basis of such factors. The only proper criterion is what's best for the patient.

"When I started in practice, an older doctor warned me especially against fee-splitters. He could well afford to talk piously, I thought at the time, since he already *had* a flourishing practice. But he was right. The man of top skill doesn't have to split fees; patients flock to him anyway. From which it follows that the man who splits fees isn't likely to be of top caliber."

The chief of service at the hospital may be a wise selection. Yet there can be disadvantages in making a referral on that basis alone.

The more obvious reasons for sending a patient to the service chief are: (a) he is presumably competent, or he would not hold that status; (b) in gratitude to the referring doctor, he may help advance the latter's career; (c) if it's a hospital case, the chief should have less trouble getting a bed than would a junior staff member.

### *G.P.'s Choice*

However, these are not sure-fire. Occasionally, it has been rumored, a doctor is made chief for other reasons than competence. Too, in some large services, the chief may be so prominent a man that he will scarcely notice the source of the referral. And he may be so busy that he will not give the case all the attention the patient expects.

Many family physicians find it wiser to select one of the intermediate-rank doctors of the appropriate service. These are usually younger men who have established their specialty status. Generally less busy than their seniors, they are likely to be more attentive to the patient—and to the referring doctor.

One G.P. interviewed offered this

tip: "Keep an eye on who writes articles in the medical journals. If Dr. X has just written a paper on the management of gout, it's a safe bet that he has given that subject a lot of study. Even if he is a rather young specialist, it seems reasonable to conclude that he has more than an average grasp of the subject."

Among physicians in general there seems little tendency, when referring, to stress board diplomas, graduate-course certificates, specialty-society memberships, and similar honors. Such documents do certify a certain amount of experience and educational background. But they're usually a weak substitute for mature judgment in determining the specialist's clinical skills.

One doctor expressed it this way: "As between a recent graduate from an OB residency, with a freshly printed board diploma, and an obstetrician with thirty years' experience in handling all kinds of difficult cases, which would you trust with your own wife's delivery?"

In picking an out-of-town specialist, however, the G.P. *has* to depend largely on paper qualifications. An official of a medical society in a resort area put it this way:

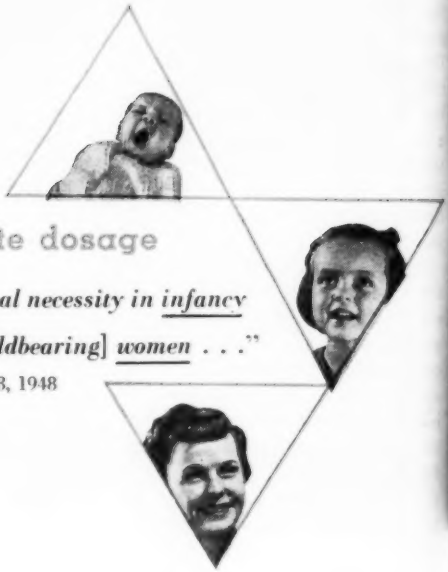
"When a metropolitan doctor has a patient who is going to spend the season here, how does he select a specialist? Chances are that he picks up a copy of the Directory of Medical Specialists and looks over the diplomates in or near our town. Then he tries to pick a man who has been out of medical school about twenty years."

Another way of selecting a specialist in a distant city is to get the hospital staff list and pick a senior man on the service concerned. The trick is to get the list. A few local medical directories list hospital staff personnel, but more often it requires some correspondence to get staff rosters.

### *Inside Job*

A within-the-specialty referral is usually done through the specialty society roster. Most of these have geographic groupings as well as alphabetic lists. For instance, if a child living in Chicago is being taken to Florida for the winter, the Chicago pediatrician probably has on his desk the membership list of the American Academy of Pediatrics. Through this he can locate a good Florida pediatrician without much trouble.

One practitioner's parting advice: "In making a remote-control referral, I'd tell the patient something like this: 'I don't know any orthopedists in that part of the country. But I see from the medical directory that Dr. X is a board-certified specialist, that Dr. Y is president of the state orthopedic society, and that Dr. Z is chief of orthopedics at the county hospital. I'm sure you won't go wrong with any of them.'" —EDWARD E. RYAN



Iron in adequate dosage

*"is almost a physiological necessity in infancy and childhood and [childbearing] women . . ."*

Sundaram, S.K.: Lancet. 1:568, 1948

*and* Feosol *is iron in its* most effective form

Feosol—both the Tablets and the highly palatable Elixir—contains adequate dosage of ferrous sulfate, grain for grain the most effective form of iron. Feosol is easily absorbed and readily tolerated. Feosol effects rapid hemoglobin regeneration and prompt reticulocyte response.

*Smith, Kline & French Laboratories, Philadelphia*

# Feosol Tablets
# Feosol Elixir

*the standard forms of iron therapy*

**Handle with care: Two historians present to Dr. George Baehr (right) the 3,600-year-old copy of a medical text written 5,000 years ago.**

# Prescriptions from the Pyramids

• The Greeks may have had a word for it, but when it came to medical matters, the Egyptians had the answers. Witness the Edwin Smith Papyrus, recently acquired by the New York Academy of Medicine. Some thirty-six centuries old, the tattered document was unearthed eighty-seven years ago by the American Egyptologist whose name it bears. Experts consider it medical history's most valued relic.

Fifteen feet in length and crawling with hieroglyphics, the papyrus looks like an overgrown Chinese laundry list. But physicians who have seen it express respect for the ancient colleague whose reed pen scratched out the forty-eight case histories contained in the scroll.

Subject matter is divided into three sections. Section 1 presents a number of surgical anatomical

# Kaomagma® with Pectin

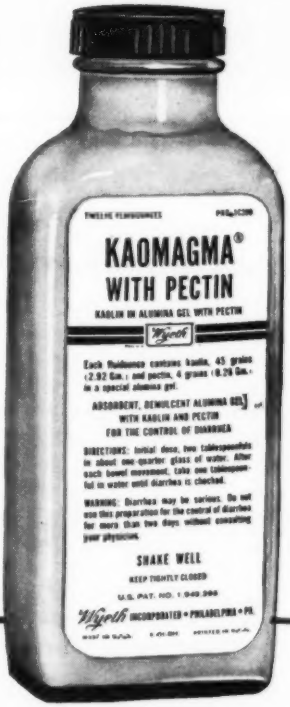
## combines three effective agents for diarrhea control

A practical and singularly effective alumina gel has been developed for its demulcent properties—to soothe and protect intestinal mucosa.

Other active ingredients are pectin and colloidal kaolin. The alumina gel is non-absorbable and holds the kaolin in suspension—thereby increasing its effectiveness. The pectin augments the water-holding properties of this ideal combination.

This unique product, Kaomagma with Pectin, quickly controls diarrhea—consolidates liquid stools, checks fluid loss, adsorbs bacteria and their toxins, and restores the patient's comfort.

It is free-flowing and has an entirely new taste especially acceptable to children. Other types of Kaomagma are: Kaomagma Plain and Kaomagma with Mineral Oil.




Wyeth®

discussions, based on actual dissections of the human body. The author describes his diagnosis and treatment of injuries of the face, neck, chest, and spine. He was well acquainted with the use of splints, bandages, and compresses. He could set broken bones and treat a dislocated jaw.

He also understood the value of conservative treatment, a frequent recommendation being to "moor the patient to his mooring stakes." In the Egyptian vernacular, this meant keeping the patient on his regular regimen and awaiting results.

Unlike most old papyri, the Smith manuscript contains little in the way of magical exhortation. What there is is limited to Section 2 of the document, titled "Incantation for Expelling the Wind of the Year of the Pest." Here we get some hocus-pocus for dealing with the "ill winds" believed responsible for epidemic plagues.

Section 3 is concerned with "Transforming an Old Man Into a Youth of Twenty." The author prescribes a facial paste of alabaster, salt, and honey.

The papyrus is currently on view at the New York academy. Some of the surgical procedures it recommends may be a little out of date, but chances are that the wrinkle-remover described in Section 3 is at least as effective as any developed in the 3,600 years since.

—NELSON ADAMS


**"You ought to see her without her girdle."**

# Split Your Estate to Cut Taxes

***Recent changes in revenue law open way to major savings on death levies***

● One of the blessings of the Federal Revenue Act of 1948 is the provision that, for tax purposes, a man may split his income with his wife. Less generally known is the fact that this provision extends also to estates. It will probably pay you —or, rather, your heirs—if you look into the matter.

The amended law permits you to leave half your estate to your wife, free of Federal taxes. The standing exemption of $60,000 can then be applied entirely against *your* half of the estate. So it's now possible, if you split your estate for tax purposes, to amass as much as $120,000 of this world's goods and still check out scot-free, as far as Federal levies are concerned.

The way to split your estate is simply to will your wife all or any part of it—without strings. If you leave her less than half, the "marital deduction" will apply only to what you actually leave her. Be sure, in figuring the size of your estate, to include *all* assets: life insurance proceeds, home, furnishings, office building, equipment, partnership stake, investments, bank account, etc.

The bigger your estate, the greater the savings available through splitting it. For instance:

| *Value of Estate* | *Tax on Split Estate* | *Tax on Unsplit Estate* |
|---|---|---|
| $100,000 | none | $ 4,800 |
| 150,000 | $ 1,050 | 17,900 |
| 200,000 | 4,800 | 32,700 |
| 250,000 | 10,900 | 47,700 |
| 300,000 | 17,900 | 62,700 |

### *Make Bequest Outright*

The "without strings" angle is important. It means that your bequest to your wife must be outright; or, if left in trust, it must meet these conditions:

¶ All income from the trust must

[*Continued on* 99]

---

**Bion H. Francis, author of this article, is an insurance consultant licensed in Massachusetts. He has written, either alone or in collaboration with others, such books as "Life Insurance from the Buyer's Point of View" and "How to Start a Life Insurance Program."*

# fits my x-ray needs to a "T" — and my budget, too! it's a Picker "Meteor"

"I want to be able to screen a chest or an extremity whenever it seems indicated. I want to be able to radiograph a chest as part of every physical examination I make — especially of new patients. I want to be able to fluoroscope and radiograph suspected fractures in the occasional emergency cases that come to my office.

I can do all that and more, *quickly* and *easily* with the Picker 'Meteor.'* Its 15 MA capacity is ample for my needs. I've had no trouble finding room for it, because it doubles as an examination table. It's a *quality* unit, made by Picker X-Ray . . . they're the people who built the Army Field X-Ray Unit we both worked with during the war. And it certainly is easy on my budget . . . cost far less than I thought I'd have to lay out for such fine equipment."

**it's simple, sure, easy to operate**

**you change easily from radiography to fluoroscopy** (or vice versa)

**vertical or horizontal** (full length of head and torso)

**it's low-priced at $1495**

**and above all, it's**

Picker X-ray

Maybe your situation parallels Dr. Jones' . . . or maybe it's altogether different. In any case, you can depend on the local Picker representative for unbiased advice, because the Picker line is a full line, embracing apparatus in *every* range, for *every* purpose.

*pateats pending


interested?

**just do this** jot Picker "Meteor" on a prescription blank, and send it to us for details. Or, if you prefer, call in your local Picker representative for the story.

PICKER X-RAY CORP.
300 Fourth Ave., New York 10, N. Y.


**For mixed infections**

*In skin grafting* Furacin has been recommended as a useful adjunct in preparing wounds and burns for grafting; as a prophylactic dressing following grafting; for treating infected edges of skin grafts.* The technics include direct application of Furacin Soluble Dressing to the lesions; use of fine-mesh gauze impregnated with Furacin Soluble Dressing; employment of Furacin Solution wet dressings. Many clinicians use this antibacterial agent routinely; some recommend it specifically when gram-negative pathogens are present. Furacin® brand of nitrofurazone, is available as Furacin Soluble Dressing (N.N.R.) and Furacin Solution (N.N.R.) containing 0.2% Furacin. These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.*

**EATON LABORATORIES, INC., NORWICH, N. Y.**

Edocet Experientia

*Coakley, W. A. et al.: Plast. & Reconstruct. Surg. 3:667 (Nov.) 1948 • Curtis, L.: Surg. Clin. N. A. 1466 (Dec.) 1947 • Mills, J. T. et al.: Plast. & Reconstruct. Surg. 3:245, 1948 • Shipley, E. R. et al.: Surg., Gynec. & Obst. 84:366, 1947 • Snyder, M. L. et al.: Mil. Surgeon 97:380, 1945 • Teplitsky, D. et al.: Plast. & Reconstruct. Surg. 3:189, 1948.

# Federal Aid for Medical Schools

***AMA relaxes opposition but calls for guards against U.S. Government control***

● Caught in the quicksand of a deepening financial crisis, the nation's medical schools need help in a hurry. The American Medical Association sounded the distress signal recently when it reversed its traditional opposition to Federal aid for medical education. The association's revised twelve-point program leaves no doubt that the survival of the medical schools depends on their getting a "quick transfusion of cash. Since not enough private support has been forthcoming, the Government, it is claimed, must provide at least part of the money.

Despite this switch, the AMA stands pat on the principle that "It is not the function of the Federal Government to build and operate medical schools." And to make sure that a financial helping hand won't develop into a political stranglehold, the association outlines these safeguards for the administration of Federal funds:

*Ceiling on amount given.* "To encourage continued local support of medical education from public and private funds, the formula for allocating Federal aid should provide only a limited portion of a school's total budget." Also, aid should not take the form of a premium that tempts schools to expand enrollment beyond their facilities.

*Limited Federal authority.* "The responsibility of officials administering the program should be limited to an audit to determine that funds are employed for the general purposes for which they were granted."

*State control.* The several states, says the AMA, should decide which schools qualify for Federal aid. A school would be considered eligible if the licensing authorities of three-fourths of the states judged its educational program of high enough quality to warrant admission of graduates to their state board exams.

*Scholarship stipulations.* "Any Federal scholarship program should leave the medical schools free in the selection of their students and should avoid the regimentation of the future careers of the recipients."

The AMA does not estimate the amount of money needed to help medical schools maintain present standards. But Alan Valentine, president of the University of Rochester, sets the figure at $40


**"He3p WAntd: MeddicA! recep tionst ;SOme exx½eRiencE r;quiRed; SAlary . . . . "**

million a year. He points out that student fees meet only 28 per cent of the average school's budget.

Although the total sum needed is not staggering, most medical educators agree that the major portion should come from private philanthropy and other non-Government sources. The feeling is that making do with as little Federal aid as possible is the best way of keeping the Government from getting its foot too far into the door.

Last month, pondering the doctors' new dictum, the men on Capitol Hill sat down to draw up their own Rx for ailing medical schools. Chances were they would heed AMA advice. —ROBERT M. HARLOW

## Estate [*Continued from* 94]

be payable to your wife for life.

¶ Income payments must be made once a year or oftener.

¶ Your wife must have exclusive power to will the principal of the trust to anyone she chooses. You cannot stipulate that the principal pass automatically to your children or other heirs.

To figure in an estate-splitting maneuver, your life insurance proceeds must meet the same conditions—unless these proceeds are turned over to your wife as a lump sum.

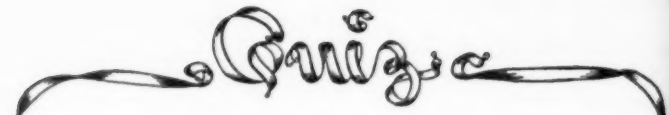
It's not a bad idea to have your insurance policies and your will rechecked to make sure they'll be able to come under the new split-estate feature. Especially is this true if you plan to leave your estate in trust, or to have your life insurance proceeds paid to your wife via interest, installment, or life-income modes of settlement.

—BION H. FRANCIS

## Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

Medical Economics, Inc.
Rutherford, N.J.




## What's Your Auto I.Q.?

• You're an expert at diagnosing human ills—but what about your ailing car? Are you baffled when your engine coughs and dies? Are you helpless when your battery goes blooey?

Here are seven problems that may crop up any time you hit the road. If you can solve five, you're good. Correct on all counts, and you're rolling in high. (Answers on 127.)

1. You're out on a night call when your lights suddenly fail. How come? And what to do?

2. The sign says, "Hospital Zone, Quiet." But your horn is stuck and blatting like a demon. How to stop it—quick?

3. You're out in the sticks with a flat. Having put on your spare, you shudder to find that you forgot to have it inflated. Do you pump or hike?

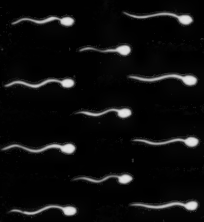
4. You're making a charity call in a tough neighborhood. Besides locking your car, what other simple precaution can you take against car thieves?

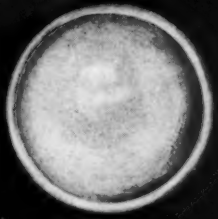
5. You're stalled, your battery's run down, and you have no crank. There's no one around to give you a push. How can you get started?

6. You asked your wife to have the oil checked, but she forgot. The gauge shows empty and it's a long pull to a gas station. How to get there without burning out a bearing?

7. Highballing down a steep hill toward an intersection, you find that both brakes and horn are out of order. What can you do besides pray?

the diaphragm + ortho-gynol = dependable contraception



the ortho diaphragm

ortho-gynol,

ortho-creme

ortho whenever indicated—wherever prescribed

# A Doctor Talks of Murder

***Takes medical profession to task for nation's high rate of homicide***

● A murder is committed in the United States every forty-eight minutes. The blame for this rate of slaughter rests on our legal system and on apathetic lawyers, politicians, and—by no means least—physicians.

So says Dr. Fredric Wertham, Manhattan authority on criminal psychology. Detailed documentation of his thesis is presented in "The Show of Violence,"* a 279-page case study of seven murders selected from the scores of which he has intimate knowledge.

Dr. Wertham points to both bungling and indifference by doctors—particularly by his fellow psychiatrists—in their handling of mental patients who later became killers.

Take the case of Robert Irwin, "the mad sculptor" who inhabited the nation's headlines for weeks back in 1937. The doctor, who played a major behind-the-scenes role at the trial, marshals both public and private records to describe the crime and its background. He notes that ten times in five years Irwin had sought aid from public medical agencies. What he got varied from sleeping pills to advice that he enter theological school.

Dr. Wertham himself had Irwin under treatment part of this time. Three times he had him committed to the state hospital, only to see him thrice discharged as "cured." It was soon after the third discharge that Irwin throttled and ice-picked a trio of victims: his former landlady, a roomer, and the landlady's daughter, a comely artists' model.

### *Snappy Story*

Slavering news writers broadly hinted rape. There was none. Irwin had long been obsessed with the idea of self-emasculation; he had asked many doctors to perform the operation, and had once attempted it himself, applying a rubber band for anesthesia. His goal was to "bottle up" his energies for greater artistic achievement. Though Dr. Wertham was able to sidetrack this particular notion, he says the violence pattern remained clear—either suicidal or homicidal.

The doctor is convinced that, given proper hospitalization and treatment, Irwin could have been

*Doubleday & Co. $3.

# RAY-TROTE IMPROVED

## a 'step-down transformer' for the management of hypertension

An *increased dose* of chemically standardized, *physiologically active* veratrum viride distinguishes the new RAY-TROTE IMPROVED CAPSULES . . . by *Raymer*. Three effective vasodilators—nitroglycerin, sodium nitrite, and veratrum viride—are combined in the green capsule. A mildly sedative dose of phenobarbital in the formula helps to maintain lowered blood pressure levels. Based on a formula used by physicians for nearly a quarter of a century . . . now made even more effective. Prescribe it in your next case of hypertension.

*Formula: Phenobarbital . . . ¼ grain; Sodium Nitrite . . . ½ grain; Nitroglycerin . . . 1/250 grain; Potassium Nitrate . . . 1 grain; with equivalent of Veratrum Viride Tincture (containing 0.1% alkaloids) . . . 4 minims; Crataegus Fluidextract . . . 1 minim.

*Also available . . . for the hypertensive patient with capillary fault . . . **RAY-TROTE WITH RUTIN** . . . representing the same formula with 20 mgm. rutin added. Supplied in two tone (green and yellow) capsule.

*Sample and literature sent on request.*
*Available at all pharmacies on prescription.*

**RAYMER**

**PHARMACAL COMPANY · PHILADELPHIA 34, PA.**

**PHARMACEUTICAL MANUFACTURERS**

*Over a Quarter Century Serving Physicians*

cured—at least to the point of forestalling the death act. For the two prominent physicians and the eminent attorney comprising the lunacy commission that declared the prisoner sane all along, Dr. Wertham has only scorn.

In a deal with New York's ambitious young prosecuting attorney, name of Dewey, the defending counsel entered for Irwin a plea of guilty to murder in the second degree. The sentence: 139 years. A few days after arriving at Sing Sing, the convicted man was pronounced psychotic by prison doctors. He is now languishing in an institution for the criminally insane.

Dr. Wertham tells of a recent letter from the prisoner asking advice about a lame sparrow he had found. He was keeping it in a box, but was afraid it would die; if he turned it free, he feared, it couldn't live, either.

### *Forgotten Sparrow*

"Ever since I got that letter," says the doctor, "I have been unable to dismiss the question from my mind: Did society, before the triple murder, ever show as much concern for sick Robert Irwin as he showed for a sick sparrow?"

In other cases, too, Fredric Wertham points an accusing finger at society and medicine—particularly at institutional and official medicine. Martin Lavin, for instance, was a professional killer who was acquitted of one murder and beat the rap on another by feigning insanity. The doctor makes no bones of his belief that psychiatrists at New York's city hospital pronounced Lavin psychotic on instructions from a high political level.

Later on, Lavin's partner in the crime was acquitted for lack of evidence, thanks largely to Lavin's time-gaining tactics and the dispersal of witnesses. Lavin immediately recovered his sanity, demanded and won his release from the mental institution to which he had been committed. He wasn't even brought to trial.

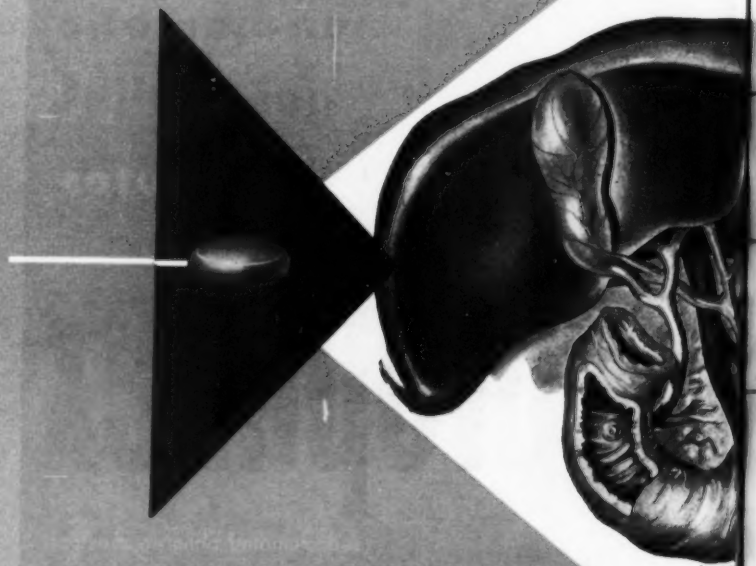
### *'He'll Do It Again'*

Some time afterward, Dr. Wertham was testifying before a legislative committee on the relationship of psychiatry to law. Lavin's name came up. Said the doctor: "He is free now—and I tell you, he will yet commit another murder."

Three months later, in a pawnshop stick-up in the Bronx, Lavin shot and killed a policeman. He was mortally wounded himself. Newspapers made much of the case and of the doctor's prediction. Reforms were demanded and official statements were issued. Through it all, the city's psychiatrists stuck to their earlier stories of Lavin's insanity, though Dr. Wertham claims to have exposed the man's malingering beyond all doubt.

After the ruckus had died down, a city official admitted to the doctor: "It would have been practically impossible to convict Lavin of

# The gallbladder therapeu



# Neocholan®

FORMULA: *Each tablet contains:*

- Dehydrocholic Acid Comp., P.-M. Co. . . . 265 mg. (4 grs.)
  - Dehydrocholic Acid . . . . . 250 mg. (3¾ grs.)
- Phenobarbital . . . . . 8.0 mg. (⅛ gr.)
- Homatropine Methylbromide . . . . . 1.2 mg. (1/50 g

# triad in one tablet...

### *Hydrocholeresis*

"If a flushing of the biliary duct is desired (even including the cystic duct) the administration of *dehydrocholic acid preparations* is preferred."[1]

### *Sedation*

"A sedative such as . . . *phenobarbital* in which is included an *antispasmodic* . . . is a *distinct adjunct* in addition to the ketocholanic acid."[2]

### *Antispasmodic Therapy*

". . . brought about freer egress of bile into the common duct."[3]

**Neocholan**—used in conjunction with appropriate dietary measures—provides a complete gallbladder regimen in non-calculous biliary tract stasis.

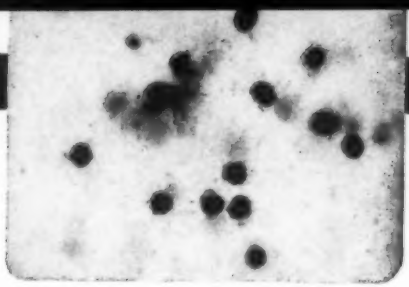
For increased efficiency, ease of administration and economy, prescribe "NEOCHOLAN (Pitman-Moore)"—bottles of 100 and 1000 tablets.

PITMAN MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS • DIVISION OF ALLIED LABORATORIES, INC.

INDIANAPOLIS 6, INDIANA

1. Bockus, H. L.: Gastro-Enterology, Philadelphia, W. B. Saunders Co., 1946, p. 576.
2. DeLor, C. J.: Bile Acid Therapy, Proceedings of the Sixth Post-Collegiate Clinical Assembly of the College of Medicine, Ohio State University, 1939.
3. Post, R. F.: Biliary Flush as an Aid in the Surgical and Non-Surgical Management



# Pyelonephritis...

Ascending urinary infections are an indication for modern and safer combined sulfonamides.

## LIQUOID®
## Mer-Diazine*

SULFAMERAZINE-SULFADIAZINE COMBINED

Palatable dispersion containing per fluidounce:

**Sulfamerazine *Microcrystalline*** ..... **1.5 Gm.**
**Sulfadiazine *Microcrystalline*** ..... **1.5 Gm.**

[Each 5 cc. (an average teaspoonful) will represent 0.5 Gm. (7½ gr.) total sulfonamides.]

## LIQUOID®
## Metha-Merdiazine*

SULFAMETHAZINE-SULFAMERAZINE-SULFADIAZINE COMBINED

Contains per fluidounce:

**Sulfamethazine *Microcrystalline*** ..... **1.0 Gm.**
**Sulfamerazine *Microcrystalline*** ..... **1.0 Gm.**
**Sulfadiazine *Microcrystalline*** ..... **1.0 Gm.**
(Tinted Pink)

[Each 5 cc. (average teaspoonful) represents 0.5 Gm. (7½ gr.) total sulfonamides.]

The least toxic of the commonly used sulfonamides are combined for additive antibacterial effect, rapid absorption, lower toxicity. Samples on request.

# McNeil
**LABORATORIES, INC.**
**PHILADELPHIA 32, PENNSYLVANIA**

*Trademark of McNeil Laboratories, Inc.

the [policeman's] murder. We would have had to send him back to the institution for the insane."

Dr. Wertham cites such eye-popping cases as the young wife who strangled her children when she learned her husband was homosexual; the kindly-looking old gentleman whose incredible perversions ran the gamut from coprophagia to butchery, castration, and cannibalism practiced on small children; and the woman who axed and burned her offspring as her private solution to the housing problem.

### *Medico's Mission*

None of these tragedies, the doctor will tell you, need ever have happened. In his writing and practice alike, he is a man with a mission: control of such cases in the future. His mission has since become his career.

Born 54 years ago in Germany, he took his M.D. degree at the University of Munich, later studied under Kraepelin, whose classification of mental diseases is still universally used.

Dr. Wertham came to this country in 1922, took a teaching post at Johns Hopkins. From 1933 to 1939 he was senior neuropsychiatrist at Bellevue, and is now director of psychiatric service at the Queens General Hospital. He is also senior psychiatrist of New York City's Department of Hospitals, and president of the Association for the Advancement of Psychotherapy.

He spends his mornings and afternoons in Queens, his evenings at one of two mental hygiene clinics he helped found: Manhattan's Quaker Emergency Readjustment Center, for the sexually malajusted; and Harlem's Lafargue Clinic, for all comers at 25 cents a head. The latter venture, housed in a parish house basement and staffed by some thirty volunteer doctors and social workers, is supported by unsolicited contributions.

These range from a stock of vitamin medications recently donated by a drug company to a milk bottle full of pennies collected by a group of children.

The doctor does his writing late at night, on weekends, and while vacationing in Maine in the summer.

"You should not ask me how I write my books," he says, "but how I live them. I interview not only the criminal, but his family, his friends, the priest, lawyers, social workers, everybody connected with the case. Often it takes years to find out what really happened."

### *Orestes in Eruption*

His previous books include "The Brain as an Organ," a text done in collaboration with his physiologist wife, and "Dark Legend: A Study in Murder," published in 1941. A popular-style "detective story of the mind," this one told of an Orestean youngster who eventually did in the object of his emotional conflicts with a bread knife. Dr.

Robin

broadens the scope of

# Effective Anti-Arthritic Therapy

## with Pabalate Liqui

From laboratory dream to clinical reality—that's the story of Robin
anti-rheumatic Pabalate, the unique combination of para-aminobenzoic acid and
salicylate which provides higher salicylate blood levels on lower salicylate d
Now, further implementing the clinical value of this important new formula, Robins offers a
outstanding research development: easily-administered, pleasant-tasting Pabalate L
With Pabalate Tablets and Liquid, the physician can now more effectively treat patient
rheumatic fever or other rheumatic disease, at all age levels—from infancy to old

FORMULA: Sodium salicylate and Para-aminobenzoic acid (as sodium salt) of
(5 gr.) 0.3 Gm. in each 5 cc. (1 teaspoonful) of a chocolate flavored liquid, or an enteric coated

INDICATIONS: Rheumatoid arthritis; acute rheumatic fever; fibrositis; gout; osteo-ar

DOSAGE: Average adult dose: two teaspoonfuls or two tablets, three times
Dosage for children proportional to age and severity of con

A. H. ROBINS CO., INC. RICHMOND 20, VIRG
Ethical Pharmaceuticals of Merit sinc

*For higher salicylate blood leve*
*on lower salicylate dosage—*

Pabalat

TABLETS AND LIQU

Rob

XUM


Days
1 10 15 20 25 30 35 40
minobenzoic acid administered (24 gm. daily)
late administered (10 gm. daily)

XUM

Wertham is also in demand as a critic of other somber-hued literary works. He authored the New York Times review of "Death of a Salesman," and extolled the candor of "The Snake Pit" on the radio program, The Author Meets the Critics.

His article on Tolstoy and violence has been called a classic contemporary essay. Lately he has been finishing up a paper on the influence of popular literature on people's minds and conduct.

It dwells largely on children's comic books. As Enemy No. 1 of this stratum of literature, Dr. Wertham has for some years written and lectured extensively on the subject. He counts among his major victories a statute recently passed by the County of Los Angeles, forbidding the sale of violent crime comics to minors.

### *Has Own Collection*

The doctor has a lot of the paper-backed horror comics in his own library. At the drop of an inhibition he'll point out the kind of violence they romanticize—to the tune of 500 million copy sales annually.

He figures that today's average 15-year-old has already lapped up some 18,000 pictorial beatings, knifings, shootings, garrotings, brandings, spearings, acid-burnings, and torturings-to-death, as well as variegated hypodermic skulduggery.

Since launching his war on the comics, Dr. Wertham thinks he has

noticed a new motif running through their pages. Nowdays, he says, they seem to specialize in the flogging, impaling, and bashing of mad psychiatrists. As a matter of fact, a movie casting director looking for someone to play such a role could do worse than to select Dr. Wertham.

### *Wrong-Way Pick*

A stooping six feet two, gaunt and horn-rimmed Dr. Wertham was once mistaken by a police reporter for the demented fiend whose case he had under study. The fiend, as usual, looked like a Baptist vestryman.

Utterly wrapped up in his work, the doctor now and then forgets such things as his own phone number. He tries never to lose touch with a case he has once examined, and his Christmas list is lengthy with lifers. "Psychiatry is the science of sympathy," he says.

But more than sympathy is needed to solve the national problem of psychopathic homicide, the doctor realizes. For one thing, people must realize that it *is* a national problem. A "perfect" murder is committed in the United States every two hours. Of every 100 murderers, says Fredric Wertham, you'll find five in jails, fifteen in mental institutions, and eighty roaming the streets, equipped by society, the law, and the medical profession with "a hunting license on human beings."

—ARTHUR MYER

SAFE, EFFECTIVE ANTI-BIOTIC THERAPY IN MOUTH AND THROAT

**Bacillus Brevis.** From a culture of this soil organism tyrothricin is extracted, purified and dried.

# LOZILLES®

**(Lah-zeels)**

**TYROTHRICIN-PROPESIN LOZENGES**

## Potent Antibiotic Action:

**The organisms most commonly responsible for acute oropharyngeal infections are extremely susceptible to the high salivary concentration of tyrothricin supplied by Lozilles.**

## Non-toxic:

**Tyrothricin is remarkable for its *lack of local toxicity* and no systemic side-effects result from its ingestion.**

## Non-sensitizing:

**The local use of tyrothricin, in contrast to topical penicillin, is remarkably free from sensitivity reactions.**

## Prompt, Long-lasting Analgesia:

**Propesin, a non-toxic, non-irritating local analgesic agent brings effective and *prolonged* relief to irritated or inflamed mucosal surfaces.**

## Palatable:

**Pleasant-tasting, Lozilles' mild citrus flavor assures patient cooperation at all ages.**

**Each Lozille contains *2 mg.* of tyrothricin and 2 mg. of propesin. Supplied in vials of 15 Lozilles.**

**WHITE LABORATORIES, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.**

# The Patient Is Always Right

***A few non-clinical case reports from the personal notebook of a perceptive M.D.***

● It was about a year ago that Mr. Laverne brought his wife in to see what could be done about her sterility. When, in the course of examining them both, I discovered that *he* had a bilateral cryptorchidism, he waxed indignant at the notion that this might have anything to do with the situation. Even laboratory demonstration of his almost complete aspermia left him unconvinced. He was as good a man as any, he wanted me to know.

As it turned out, he must have been. For just the other day Mrs. Laverne dutifully gave birth to a little girl. Her name, according to the announcement, is Faith.

° ° °

The long travail of recurrent gallstone colic led Mrs. Goldwater at long last to the operating table. There I relieved her of a shrunken gall bladder containing a single stone. A few days later, as I was removing the sutures, she picked the stone off her bedside table and held it up.

"Doctor, was this really all I had in my gall bladder? Mrs. Frobish had the same operation and they took maybe fifty stones out of her."

I assured her that the solitary stone had caused all her troubles. She regarded me a moment in silence, her eyes narrowing. Then, "You know something, Doctor? This thing looks just like the pills you were giving me before the operation."

° ° °

At the Gilhooley home, the baby's chickenpox had been for several days the subject of a difference of opinion between the mother and the grandmother. I had been called primarily to settle the argument. The frowzy and aggressive mother greeted me at the door.

"Doctor, I want you to look at my baby's measles. She itches terrible. I keep telling my mother-in-law it's measles and she keeps hollering it's chickenpox. You can see for yourself."

I pronounce grandma the winner. The mother turns into an ominous thundercloud. As I hand her the prescription for an antipruritic lotion and begin to explain its uses, the storm breaks:

"Do you think I'm crazy enough to put this stuff on my baby? What kind of a doctor are you, anyway?

# all Eve's daughters

are susceptible to pruritus vulvae, a most distressing symptom. The patient can be relieved promptly, and safely, with Calmitol Ointment.

PROMPTLY: the active ingredients of Calmitol—camphorated chloral, hyoscyamine oleate and menthol—block the pruritic impulse at its origin in skin receptors and nerve endings;

AND SAFELY: the Calmitol formula carefully excludes stimulating or keratolytic drugs such as phenol, cocaine, and cocaine derivatives.[1-4]

**CALMITOL**


1. Underwood, G. B., and Gaul, L. E.: J.A.M.A. *138*:570, 1948.
2. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. *130*:249, 1946.
3. Andrews, G. C.: Diseases of the Skin, Philadelphia, W. B. Saunders Co., 1946.
4. Gaul, L. E.: J.A.M.A. *127*:439, 1945.



*Thos. Leeming & Co. Inc.* 155 EAST 44th STREET, NEW YORK 17, N. Y.

What are you trying to do—drive the measles inside?"

• • •

Not every charity patient accepts our city's tender mercies with equal grace. A particularly cynical beneficiary was Mrs. Nolti, a remarkably multiparous lady, whose last accouchement was attended at her home by Interne Clements. Two days after the event, when Dr. Clements dropped in to see how the lady was getting on, he found her holding an ice bag to her bosom.

"Are you having trouble with your breasts?" asked Clements.

"Oh, no!" quoth the lady, with elaborate sarcasm. "No trouble. I only do this to keep the milk fresh."

• • •

Mrs. Marzek, primigravida and distraught, comes in two weeks ahead of her appointment. She has been warned about ominous symptoms which must be reported at once; so I wonder briefly which of the possible complications of pregnancy I am about to deal with.

"Doctor," she says, "my girl friend tells me a permanent wave doesn't hold when you're pregnant. Can you give me something to make it stay in?"

• • •

Mr. Warren's sudden seizure with chest pain seems a classical instance of coronary thrombosis. His wife looks bewildered at the words, "heart attack."

"But Doctor," she says, in a mildly accusing tone, "how is that possible? You've been taking care of him for the past two years."

Well yes, so I have. In the past two years I have seen Mr. Warren twice: for incision of a paronychia and for removal of wax from his ears. Somehow, my conscience is strangely untroubled. There are limits to preventive medicine.

• • •

Sometimes, when I hear colleagues criticizing the specialty boards, I'm moved to point out how much the boards have done toward implanting in the public mind the particular skills to be found in the various branches of medicine. Take

## Pre-Natal Influence

• I was just establishing a small town practice when I delivered a young wife of a six-fingered, six-toed child. There was much speculation on the phenomenon among the townspeople, with explanations ranging from pre-natal marking to various aspects of the mother's diet. But the pattest of all was vouchsafed by a positive matron who declared, "It's simply what comes of having a young, inexperienced doctor." —M.D., MAINE



# Which would you prescribe for Infant Feeding?

**NATURALLY,** you'd choose a name you know... a name worthy of your confidence.

**AND CARNATION** *protects* your recommendation with the most scrupulous standards of safety, uniformity and nutritional value.

**EVERY DROP** of Carnation Milk is processed with *"prescription accuracy"* —in Carnation's *own* plants under Carnation's *own* continuous supervision. That is why you can have complete confidence in Carnation. It is evaporated, homogenized, enriched in vitamin D, and sterilized, under the most rigid controls. Constant tests and vigilant inspection are your guarantee that every can bearing the name Carnation meets the highest requirements of the medical profession.

**NO WONDER** 8 out of 10 mothers who use a Carnation formula say, *"My doctor recommended it!"* It's the milk you can confidently *prescribe by name*—day in and year out.

*Carnation Evaporated Milk is an especially suitable milk for infant feeding and for bland and special diets.*



**The Milk Every Doctor Knows**

*"From Contented Cows"*

what happened at the hospital the other day.

A woman burst into the clinic, frantic with anxiety and pulling a bawling four-year-old after her. "Nurse!" she exclaimed. "Where's the orthopedist? I need a bone specialist at once!"

The nurse rose hastily from her desk. "What's happened?"

"Don't just stand there!" the woman shrilled. "I need an orthopedist. Sonny here has just swallowed a fish bone!"

• • •

Old Professor Bond, who still feels there is no place for females in medicine, thinks up a new deterrent every year. At the very first session this year, after selecting a group of patients for the medical seminar, he gives Miss Dow, a pretty third-year student, her assignment. She is to take a history before the entire group from a deaf patient whose chief complaint is impotence.

• • •

After two patients in succession had died in N224, the room became the "funeral parlor." No patient would stay in it. Each new admission was promptly apprised of the "hant," and it soon became evident that 224 was destined to become a linen room unless its reputation could be restored.

"Before we cut down our capacity," suggested the superintendent, "why don't we plant some ambulant patient about to be discharged in this room, let him stay two or three days, and break the jinx?"

So it was. John Lithberg, eight days post-herniorrhaphy and ambulant, became the new inmate of 224. Early the following morning, when the nurse peeked in on her rounds, she found Mr. Lithberg peacefully dead in bed. At autopsy, the pelvic phlebitis and massive pulmonary embolus provided sufficient explanation. But just the same, nothing more mortal now dwells in 224 than towels and bed sheets.

• • •

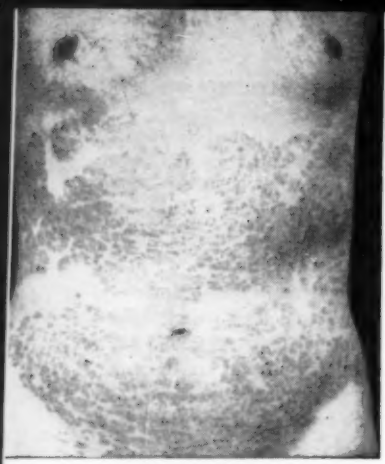
The old one about a successful G.P.'s needing a case of hemorrhoids to give him a look of concern didn't seem particularly amusing a few months ago. I had that look of concern. After the kind of stalling around that one condemns in a patient, I finally stopped in to see my proctologist friend, Bill Barat.

As he scoped and probed, Bill discussed the situation with me: "Hmm . . . yes. Foolish fellow. You've been eating those rich pastries for years, even though you knew they were bad for you."

He certainly had me dead to rights. I couldn't help wondering how he could tell. Just goes to show, I thought, how out of touch you can get with the other fellow's specialty.

Bill was probing and talking again. "Hmm, bacon too. Matter of fact, you helped yourself to a few extra rashers this morning, eh?"

"Sa-ay!" I burst out. "You mean



*Before Use of Riasol*

*After Use of Riasol*

# RIASOL in PSORIASIS


## a VICTOR in the finals

**Victors in the tennis finals seldo win by accident. Hours of practic proper form, and skill in placin balls all contribute to final victor**

**RIASOL, an outstanding formul for treating psoriasis, is no accide tal discovery. Controlled clinic tests and years of actual use pro that RIASOL is definitely a victor the field of psoriasis.**

**RIASOL has an enviable record of chievement. It clears disfiguring, cutane patches of psoriasis in most cases. Rec rences are usually minimal. Because it simple, convenient and pleasant to u RIASOL enjoys patient acceptance, operation and satisfaction.**

**Contains 0.45% mercury chemically co bined with soaps, 0.5% phenol and 0.75 cresol in a washable, non-staining, odorl vehicle.**

**Apply daily after a mild soap bath a thorough drying. A thin, invisible, e nomical film suffices. No bandages nec sary. After one week, adjust to patien progress.**

**RIASOL is promoted ethically. Supplie in 4 and 8 fld. oz. bottles, at pharmac or direct.**

**MAIL COUPON TODAY- PROVE RIASOL YOURSEL**

**SHIELD LABORATORIES** ME-9-49

12850 Mansfield Avenue, Detroit 27, Mich.

Please send me professional literature and generous clinical package of RIASOL.

..... M.D. ..... Street

City ..... Zone ..... State .....

Druggist ..... Address .....


RIASOL FOR PSORIASIS

you can tell all that with a scope?"

"Scope helps, of course," he said. 'Fact is, though, your wife phoned and told me you were coming. Asked me to warn you about your eating."

• • •

One of the most likable patients I ever had was a structural steel worker named Bill Domesne. His claim to immortality, and very nearly to mortality as well, was a carotid sinus of such hair-trigger sensitivity that a yawn or a slight turn of the head was enough to induce sudden unconsciousness. What ever kept him from tumbling off one of his skyscraper perches before he decided to consult a doctor, I'll never know. What's more, I had a tough time talking him into giving up his job in favor of some other line of work. Finally, though, I succeeded.

A couple of weeks later I was about to step off the curb at a busy downtown intersection when a taxi screeched to a halt directly in front of me. Bill stuck his grinning face out. "Give you a lift? It's my cab."

"Well, I . . ."

"Come on—it's on me."

With an unwonted burst of courage, I climbed in and he drove me home. We didn't hit anything, or even come close. But I couldn't avoid an uncomfortable feeling of unethical behavior—a little like ambulance chasing.

—MARTIN O. GANNETT, M.D.

**"She says the pains are just close enough together to boil an egg soft."**

*for a*

# PHYSIOLOGIC FALL

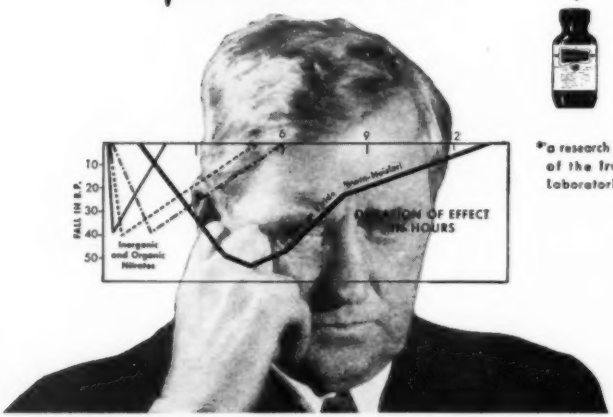
*in blood pressure*

Of the many drugs used to lower arterial pressure in hypertension, Biologically Standardized veratrum viride (in CRAW UNITS*) is the only drug that produces a physiologic fall in blood pressure. VERATRITE represents a practical modification of this effective hypotensive drug for everyday management of the mild and moderate cases of essential hypertension. Prolonged action, wide range of therapeutic safety and complete simplicity of administration are specific advantages of Veratrite therapy. Each Veratrite Tabule contains: Biologically Standardized veratrum viride 3 CRAW UNITS; sodium nitrite 1 grain; phenobarbital ¼ grain.

**Samples and literature on request.**

IRWIN, NEISLER & COMPANY DECATUR, ILLINOIS

# Veratrite®




*a research development of the Irwin-Neisler Laboratories

# You're Not a Free Agent!

***How one town's M.D.'s have organized for group action on professional problems***

• Dr. Smith's new patient is discussing his gastritis: "I've been seeing Dr. Jones about it, off and on, for nearly a year. Frankly, I don't think that fellow knows much about stomach trouble."

"You may be right," Dr. Smith says casually. "As a matter of fact, Jones doesn't give the impression that he knows too much about anything."

Backstabbing? Sure. But what physician hasn't heard of the same sort of thing in his own locality? It probably goes on most everywhere —with the noteworthy exception of one eastern town, whose doctors have joined forces to solve such intra-professional problems.

The Caduceus Club of Pawtucket, R.I., is a non-scientific body where members can shape and enforce a brass-tacks code of professional, public, and patient relations. They meet periodically to air their gripes, talk over economic matters. Thanks to open-and-above-board discussion (plus occasional man-to-man confabs), ethical peccadilloes of the Smith-Jones variety have all but disappeared from the community.

The club restricts itself to local, workaday problems. Take the question of osteopathic referrals. In Rhode Island, the D.O. enjoys a status almost on a par with the M.D. Caduceans who refer patients to osteopaths without making it absolutely clear that the latter are *not* doctors of medicine are tactfully reminded of their lapse by other club members.

The club meets at irregular intervals, on call of its officers. The discussion may touch on anything from fair fee-setting to public health questions.

### *Doctors' Task Force*

For instance, a public health official let it be known a while back that he was planning a free clinic. Its services were to be available to all comers, regardless of means. A delegation of club members called on the health officer, argued that such a center should be for the medically indigent only. They won their point.

Why not iron out such matters in the county medical society? Says one Caducean: "Fellows at the other end of the county aren't in-

terested in our local headaches in Pawtucket. Besides, the county meetings are mostly scientific. When they are on economics, the subject is usually broader than the day-to-day things we deal with."

A case in point was the problem of after-hours service to patients. The Caduceus Club thrashed out the matter at a number of meetings, then set up a physicians' exchange and roster system. Now, there's always a club member ready to answer emergency calls nights, Sundays, and Wednesday afternoons. Such a service, of course, is nothing new. But, with a ready-made organization for tackling just such problems, Pawtucket medical men handled this one with dispatch and with a minimum of friction.

The Caduceus Club was founded thirteen years ago, chiefly at the instigation of a group of the town's younger physicians who felt that some such body was needed to smooth intra-professional relations. Current officers are Dr. Orland F. Smith, president; Dr. Edmond C. Laurelli, vice president; and Dr. Harold A. Woodcome, secretary.

Admission to the club is by unanimous vote of the membership. However, its present forty members include nearly all of Pawtucket's practicing physicians. One point impressed on each new man: "We believe in solving our problems by hearing from all interested members, then by presenting a solid front to the lay public. As a Caducean, you're *not* a free agent."

—ALLEN ELY

## Auto Answers [*See page* 100]

1. Nine times out of ten, the gremlin is a blown fuse. This gadget, little bigger than a capsule, is usually located up under your dash panel, behind the dashboard light switch. Keep a 25-cent tin of spare fuses in your glove compartment—plus a flashlight to use when changing them.

2. When you've raised the hood, don't take time to hunt the short circuit. Just undo any of the wires connected to the horn.

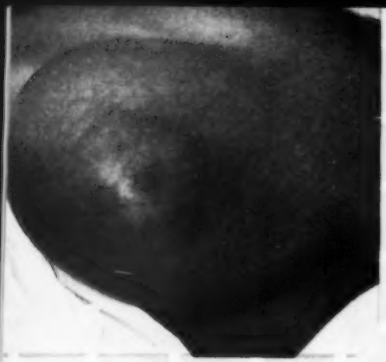
3. Neither, if you carry an air cartridge. This small, sealed tube will fill an empty tire or furnish emergency pressure against a slow leak. Once used, it can be refilled at any free air pump.

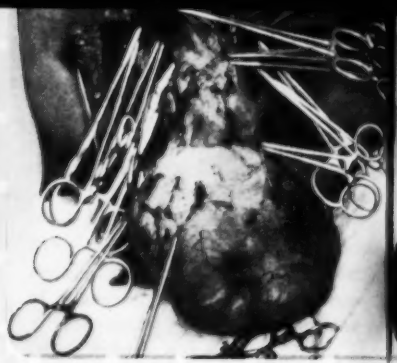
4. Stuff a rag tightly into your tail pipe, out of sight. The car can't be started with a blocked exhaust.

5. Shift into second or high. Jack up one rear wheel and remove the hub cap. Turn on your ignition. Then, with your lug wrench, revolve the jacked-up wheel rapidly.

6. Pour a gallon of water into the oil chamber. Drive slowly, with an eye on the oil pressure gauge. When it starts to fall, put in more water. Going down hills, turn off the engine and coast.

7. Leave car in gear but turn off the ignition. The resulting barrage of backfires will herald your approach like a twenty-one gun salute. As a last resort, you can throw the car into low or reverse. It won't do the gears any good, of course, but it should get you stopped. END





# Picture the patient's progre

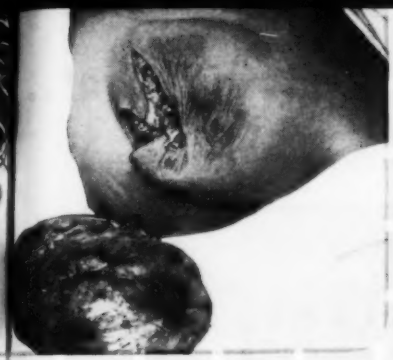
## *. . . with photograph . . . after photograph*

An effective motion-picture presentation with 16-millimeter sound or silent films is easy with Sound Kodascope FS-10-N Projector. In addition, with a microphone attachment, voice or other sound effects can be added to silent projection . . . with extra equipment, either or both may be "mixed" with the output from sound film. These are some of the many features of Sound Kodascope FS-10-N Projector that give the showing of 16-millimeter motion pictures the truly professional touch. For further information about this product, see your nearest photographic dealer . . . or write to Eastman Kodak Company, *Medical Division*, Rochester 4, N. Y.

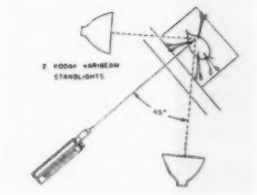
*Major Kodak products for the medical profession*

X-ray films; x-ray intensifying screens; x-ray processing chemicals; electrocardiographic papers and film; cameras—still- and motion-picture; projectors—still- and motion-picture; enlargers and printers; photographic films—color and black-and-white (including infrared); photographic papers; photographic processing chemicals; synthetic organic chemicals; Recordak products.

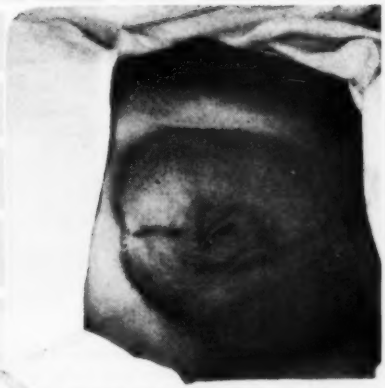
*Serving medical progress thr*otog

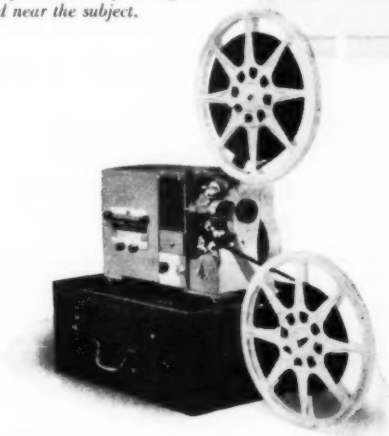


*Four views depicting successive stages in the surgical resection of a tumor of the mammary gland.*




*In the making of surgical motion pictures, anatomic features stand out clearly when one of the lights is placed near the subject.*





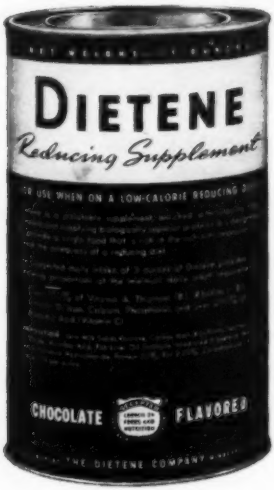
*thr[o]tography and Radiography*

Kodak

TRADE-MARK

# It is a Question of Management..

The treatment of obesity is simple. It is the management of the obese patient that presents the problem.




DIETENE® is of real value in the management of the obese patient, particularly during the early days of diet restrictions, when the pangs of hunger may tempt the patient to deviate from the regimen.

DIETENE supplies essential protein, vitamins, and minerals in a very palatable form. One-pound cans, plain or chocolate flavor, are available to patients through all pharmacies at $1.55.

Send for your *free supply* of the 1000-calorie Dietene Reducing Diets. Diets are made up to look as if they were typed in your office for the individual patient.

Specify DIETENE in reducing diets to maintain adequate protein-vitamin-mineral intake.

---

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Not advertised to the laity

**THE DIETENE COMPANY**
518 FIFTH AVENUE SOUTH, MINNEAPOLIS 15, MINN. **Dept. DE 99**

Please send me a *free* supply of the 1000-calorie Dietene Reducing Diet.

Name..... M.D.
(Please Print)

Address.....

City..... Zone.... State.....

# The 'Loyal Opposition' Speaks

***AMA is urged to champion an aggressive movement for the extension of medical care***

● The victories of medical science have created an informed population that demands medical services of quality and quantity heretofore unknown to them. What do we, the professional men of today, have to say about it?

To be specific, what position is the doctor to take with regard to the extension of the public health movement, with its steady encroachment upon the private practitioner; with regard to prepayment schemes for the provision of medical services, which tend to fix fees and to impersonalize the economic arrangements of practice; with regard to the use of public moneys to support medical education and medical research; with regard to the concept that medical care should be as available as pure water, and that it is the responsibility of Government to see that its people have this necessity? How do we physicians react to all these questions?

A subsidy of some sort is involved in many of these questions. Subsidy is not a popular word in certain quarters. But consider this fact: Only a small percentage of the population can pay its way when confronted with serious illness. Should not we subsidize all of the indigent sick in order that they may be able to share the advantages of "the golden age of therapeutics"?

### *Howlers Also Benefit*

Perhaps this is contrary to the rugged individualism of the so-called American way of life. Yet some of those who howl the loudest for free enterprise and a competitive economy are themselves beneficiaries of governmental lar-

---

** Dr. Hugh J. Morgan, whose recent talk before the North Carolina State medical society is highlighted here, is one of the 150-odd medical leaders who publicly asked the AMA last spring for a "less indefinite, more constructive" program. Dr. Morgan is professor of medicine at the Vanderbilt University School of Medicine. He is also a past president of the American College of Physicians.*


*ALSO KNOWN AS DETTOL

## A proved antiseptic for obstetrical and surgical use

● Dett, known as Dettol throughout the British Empire and other parts of the world, is now available to the medical profession of the United States.

Dett, although deadly to germs, is gentle to human tissue. This clean, clear liquid with an agreeable odor is safe, effective, non-irritating and non-staining. Physicians who have used Dettol in other countries will welcome its introduction in the United States under the name of Dett.

For a generous size sample, and literature, write to: The R. T. French Co., Pharmaceutical Dept., Rochester 9, New York.

**DETT** *THE MODERN WEAPON AGAINST INFECTION*

gess. Government, at one time or another, has subsidized railroads, shipping, the airlines, and the farmer; it protects American business against foreign competition; it provides free education; it assists veterans. Here is subsidy on a wide front.

Medical education costs four to eight times its tuition fees. If, through tax-favored philanthropies, we subsidize medical students in amounts four to eight times greater than their own contribution to their education, is it inconsistent or un-American to subsidize the sick so that they may obtain what these doctors have to offer?

The people want more and better medical care. Most people want it for all the people, whether all the people can pay for it or not. They and their representatives in government are determined to have it if it can be gotten by passing laws. I am wholly sympathetic with the President's objective. My disagreement with him has to do with ways and means only—and I believe this is the way doctors in general feel.

There has been a great deal of loose talk about "free enterprise" in medicine, and also about "socialized medicine." Let me say a few words about the latter.

Socialized medicine is medicine under complete government control—the levels of authority being Federal, state, county, and municipal. The medical departments of the Army, Navy, Air Force, Public Health Service, and Veterans Administration are socialized at the Federal level. Our state, county, and municipal institutions are socialized at local levels.

There are 1,425,000 hospital beds in the United States. Half are for general care; the other half are for long-term diseases. Almost all the beds for long-term illness and about half the general hospital beds are being operated by government. Thus, less than 400,000 of the 1,425,000 beds in the United States operate under free enterprise.

When all these beneficiaries of

## A La Carte

• A young mother with a year-old child arrived tearfully at the hospital clinic one cold winter evening. "I wanted to warm up his potty before he sat on it," she explained, "but must have gotten it too hot." The resident applied first aid to the circular burn on the little fellow's buttocks, then decided the baby should be admitted to the ward for further treatment. On the admission slip he penned the diagnosis: "Pot Roast." —ARTHUR B. PEACOCK, M.D.

government health services are added together, the number of the population left to be cared for under the private-enterprise system is startlingly reduced. Actually, the practicing physician is cooperating extensively, with or without remuneration, in Federal, state, county, and especially municipal socialized medicine.

Is this socialized medicine, as we have seen it for years, so pernicious as to be altogether condemned? I would say that medicine in the Army, Navy, Air Forces, and Veterans Administration is good, over all. I would say that it is far better than that practiced in the *average* home or hospital throughout the country. I make the statement on the basis of extensive observation.

What about the effect upon the doctor of working in such a system of socialized medicine? What happens when the factor of competition is sharply curtailed—when the operation of the profit motive is abolished or greatly diminished? I do not think that anything much happens, if professional standards are safeguarded.

I do not put preservation of the private-enterprise principle in medicine before preservation of the professional principle. What of the doctor whose concept is so narrow as to preclude ministration to the people except in an atmosphere of free enterprise and competition? He has ceased to be a professional man and has become a businessman. [*Continued on* 137]

# Further Clinical Results with Undecylenic Acid in Psoriasis

### *New series of cases treated with Declid Capsules*

● Oral administration of undecylenic acid in psoriasis, first reported from a private practice series,[1] is further scrutinized in a second publication[2] dealing with a series of clinic cases.

Forty cases which had proved refractory to other therapy were treated exclusively with undecylenic acid (Declid Capsules), for a period of 2 to 27 weeks.

### *Degrees of Improvement*

Twelve patients (30%) were "Improved;" 15 (37%) were "Somewhat Improved;" 10 (25%) were "Unchanged;" (7%) were "Worse."

"Improved" designated very substantial degrees of recovery; "Somewhat Improved" meant less impressive, though distinct improvement. In some cases, regression preceded favorable response. No serious or lasting toxic effects were observed.

### *Tolerability*

Declid Undecylenic Acid Capsules have been given in large daily doses over long periods without toxic symptoms or significant side reactions.

Some patients report a bitter taste, mild nausea, or belching. These are relieved by antacids. Increased bowel activity is sometimes noted. When justified, reduced dosage or temporary cessation is advised. These side effects, in most cases, do not appear when full dosage is resumed.

### *Dosage*

Uniform or immediate response should not be expected. In each case, the dosage should be adjusted to the individual patient's response. Higher dosages generally produce proportionately greater effect.

The capsules may be taken between meals, after eating, or with food, as best tolerated by the patient. Suggested dosages:

*First Week:* Four Declid Capsules 3 times daily. This dosage may be continued if response is satisfactory.

*Second Week:* Six Declid Capsules 3 times daily, if needed.

*After Second Week:* 8 to 10 Declid Capsules 3 times daily if needed, and continued until complete disappearance of lesions.

Tolerability is enhanced by taking capsules with a carbonated beverage.

### *Adjunctive Therapy*

When response to undecylenic acid therapy is slow, the conventional psoriasis treatments can be useful adjuncts. Low fat diets and topical applications may accelerate results.

### *Contraindications*

Oral therapy with Declid Undecylenic Acid is new. Much is still unknown about its effect on metabolism. It should not be given to debilitated, diabetic or hypertensive patients, or those with coronary or gall bladder symptoms.

Declid Undecylenic Acid Capsules are to be dispensed only by or on the prescription of a physician. Supplied in Bottles of 100 or 1,000 Capsules, 0.44 gram each. Complete literature on request.

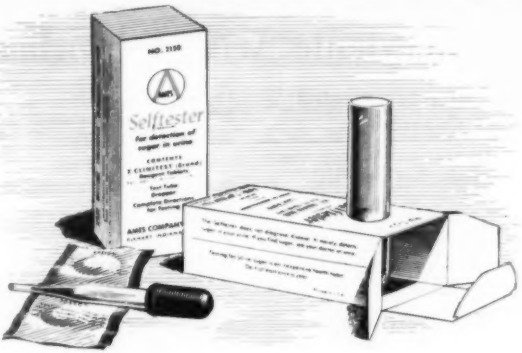

REFERENCES

1. Perlman, H. H.: Undecylenic Acid Given Orally in Psoriasis and Neurodermatitis, J.A.M.A. 139:*444* (Feb 12) 1949.

2. Perlman, H. H., and Milberg, I. L.,: Peroral Administration of Undecylenic Acid in Psoriasis, J.A.M.A. 140:*865* (July 9) 1949.


# Declid Undecylenic Acid


**DECYL PHARMACAL CO.** *Distributors*
**PRINCETON, N. J.**




# For the public good

The health and well-being of at least 1,000,000 Americans depends upon their discovery and treatment as diabetics. The American Diabetes Association is directing the year-round Diabetes Detection Drive to find the "1,000,000 unknown diabetics" and guide them to their own physicians for treatment.

**THE AMES** *Selftester* (TRADEMARK) **AT ALL DRUGSTORES**

brings those with glycosuria to you for diagnosis.

A simple home screening test for urine-sugar, the Ames Selftester* is a new approach to this detection problem. Like the clinical thermometer, it is sold directly to the public through drugstores. Also like the thermometer, it does not give a diagnosis, but only a warning.

***the directions state:***

**1. The Selftester does not diagnose diabetes or any other disease.** Its sole function is the detection of sugar (glucose) or sugar-like substances.

**2. If reaction is positive, see your doctor at once.** Sugar in your urine does not necessarily mean you have diabetes (nor does a negative result definitely exclude the presence of disease). But only your doctor, by medical examination and by additional laboratory tests, can tell why you show sugar.

**THE AMES** *Selftester* ***to detect*** **CLINITEST®** ***to control*** **Brand • Reagent Tablets** } **THE DIABETIC**

*Approved by the Council of the American Diabetes Association and accepted for advertising in publications of the American Medical Association.

AMES COMPANY, INC • ELKHART, INDIANA

I am sick of hearing our professional leaders insist and re-insist *ad nauseam* upon the "preservation of the private-enterprise system in medicine"—as though this economic principle were an ethical, moral, or professional matter.

It would appear that, for these doctors, the economics of medicine overshadows the professional concept, outweighs the sole *raison d'etre* of the practitioner: ministration to the people.

Let us not take the tradesman's view. It is one thing to oppose socialized medicine because it would impersonalize and degrade the practice of medicine; because it promises services which simply cannot be provided at this time; because it would defeat the healthier approach to improvement of medical services through voluntary arrangements.

But it is quite another thing to be intemperate, illogical, inaccurate, selfishly materialistic, and misinformed. It behooves the members of a learned profession to mark well this point.

### *Wave of the Future*

What about health insurance? The people want it and are going to have it. The question is merely whether it will be Government insurance or private insurance. I strongly favor the latter and have spent a great deal of time working for it and against Mr. Ewing. But I would vote for Mr. Ewing's plan unless a better one is offered.

I believe that the American Medical Association should become the champion of a movement to improve and extend medical care in the United States.

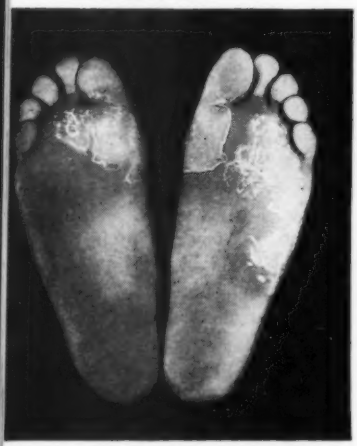
The AMA, as a professional society, must recognize—indeed, insist—that medical care in the United States has to be improved and extended. It should reclaim its position of leadership by emphasizing its professional responsibilities, by ceasing to advocate merely the preservation of the *status quo*.

This, and not mere opposition to Murray, Wagner, and Dingell, is the role for us to play. This is the way for us to reclaim prestige due us as professional men in medicine. Most important of all, this is the way for us to help the people obtain more and better medical service.

Only by this method can we help our people experience the enormous benefits of living in this, the golden age of therapeutics. END

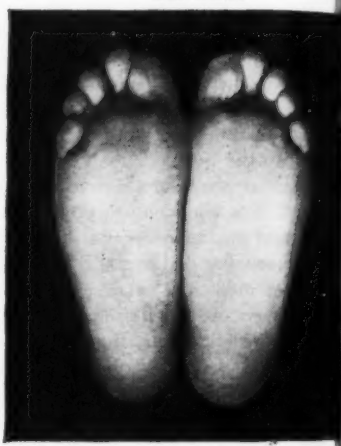
# ONLY WITH *Octofen*

BEFORE



Athlete's foot, 12 years duration, October 1, 1948.

AFTER



Same case, January 2, 1949, after 3 months' treatment.

Spectacular results in treatment of dermatophytosis are almost a daily occurrence when **Octofen** therapy is instituted.

***Try Octofen on your most severe case—See what a true fungicide can do to relieve this condition!***

*Octofen*®

A TRUE FUNGICIDE

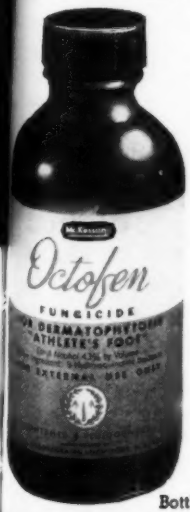
Potent! Nonirritating! Greaseless!

**THE SUPERIORITY OF OCTOFEN**

# CASE OF ATHLETE'S FOOT of 12 years' DURATION CLEARED IN 3 MONTHS!

This case of dermatophytosis, of 12 years' duration, failed to respond to many types of therapy. Treatment twice daily with **Octofen** began on October 1, 1948. Patient was last seen on January 2, 1949 at which time the lesions had cleared.

The medical profession continues to praise **Octofen**, recognizing these vital factors:




Octofen **is a true fungicide which kills fungi on contact.**

Octofen **has been shown to clear up athlete's foot in from 1 week to 3 months, depending upon severity of the case.**

Octofen **has shown no primary irritation or sensitization in clinical work to date.**

Octofen **makes overtreatment dermatitis unnecessary.**

Octofen **is entirely free from notorious irritants, heavy metals, tars, oils, phenols or alkalies.**

Octofen **is potent, nonirritating, greaseless.**

**Bottles of 4 Ounces For Your Rx Convenience**

**McKesson & Robbins, Incorporated** **Dept. M.E.**
**Bridgeport 9, Connecticut**

Gentlemen:

Please send me FREE, four 1-oz. sample packages of **OCTOFEN**—sufficient to test its efficacy—and descriptive literature.

Name_____ M.D.

Address_____ City & State_____

**IS MEASURED IN FEET SUCCESSFULLY TREATED!**

# Interne Plan Aids Local Doctors

***How a unique educational project enables one hospital to attract more internes***

● The number of approved interneships offered by U.S. hospitals totals about 9,000. Available internes number less than 6,000. Result of this disparity is a competitive scramble for house staffs, in which the small hospital must bait its hook with special ingenuity.

One such institution with a highly successful interne recruiting plan is the Atlantic City (N.J.) Hospital. This 320-bed plant gets its pick of internes through a unique, on-the-job training program that utilizes "visiting chiefs pro tem." Eight months ago, 1,500 pamphlets announcing the program's adoption were circulated among junior and senior medical students. Interne applications are now the heaviest in five years.

To get these results, Dr. Hilton S. Read, director of interne and resident education at the hospital, had to unravel a pair of tough problems: (1) how to capture interne interest with a dramatic, appealing idea; (2) how to mesh the new program with routine work so that neither one would slight the other.

Here's his solution:

Fifty-two established practitioners, all tops in their fields, are invited to spend one week each at the hospital. This means that throughout the year a nationally recognized teacher or clinician is always in residence. During his week's stay he makes ward rounds on his service, holds seminars, lectures on one of his special interests, and participates in the clinical pathological conference. "When these men get here," says Dr. Read, "they really let their hair down. They give. And they're intrigued with the idea of pioneering in a teaching experiment like this one."

### *Magnet for M.D.'s*

To prevent internes from becoming too loaded with cases to take advantage of its visiting-chief plan, the hospital got the number of its approved interneships upped from eight to twelve. It also got staff physicians to agree not to call on internes while regularly scheduled training classes are in session.

Besides giving internes a chance to rub elbows with some of the nation's best physicians, the program is a boon to local doctors.

[*Continued on* 144]

announcing another Robins' achievement

*Gastrically soluble outer shell contains pepsin; enterically coated core contains pancreatin and bile salts.*

By the development of an entirely new
of coated tablet, consisting of a gastri
soluble outer shell containing pepsin, an
enterically coated core containing pancr
and bile salts—Robins (with their new pro
Entozyme) now makes it possible to re
these three important digestants *in fully*
*form* to that part of the gastrointestinal
where pH conditions for optimum activity pre
Clinical research[1] indicates that Entozy
greatest field of usefulness is in chr
cholecystitis, post-cholecystectomy syndr
subtotal gastrectomy, infectious hepa
pancreatitis and chronic dyspepsia—whe
unique selective therapy restores more n

ENTOZYME

Robins

XUM

# ...ew TRIPLE-ENZYME DIGESTANT

## ...ith unique Peptomatic* Action!

...ely new ...siological conditions in the gastrointestinal ...a gastri...act. It is also highly effective in nausea, ...psin, an...orexia, belching, flatulence and pyrosis. ...g pancr... peptic ulcer patients, too, pancreatin-pepsin ...new pro...erapy has produced excellent results.[2]

...le to rel... Each specially constructed tablet contains ...fully a...reatin, U.S.P., 300 mg.; Pepsin, N.F., 250 mg.; ...e Salts, 150 mg.

...testinal ... 1 or 2 tablets after each meal, or as directed ...vity pre... physician, without crushing or chewing.

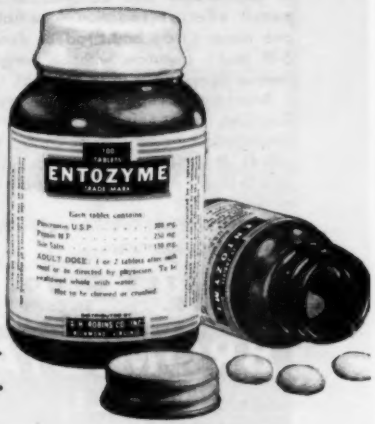
...Entozy... Bottles of 25 and 100.

...is in chr... 1. McGavack, T. H. and Klotz, S. D.: Bull. Flower ...th Ave. Hosp., 9:61, 1946. 2. Weissberg, J., McGavack, ...r syndr... H. and Boyd, Linn J.: Am. J. Digest. Dis., 15:332, 1948.

...us hepa... *coined word to describe the unique mechanical action of ...nzyme Tablet—whereby pepsin is released only in the ...mach, and pancreatin and bile salts only in the small intestine.

...a—wher... **H. ROBINS COMPANY, INC.** • RICHMOND 20, VA.

...more ne... *...ical Pharmaceuticals of Merit since 1878*



Each day members of nearby county medical societies are invited to a talk given by the visiting chief. The hospital's five residents also get a bid. Attendance at these meetings averages about twenty-five physicians, has run as high as fifty.

The invitation to Atlantic City has a double appeal for the visiting chiefs.* It combines the opportunity to participate in a new educational experiment with the pleasure of a semi-vacation at the seashore. "Every man who has been here,"

*The roster of visiting chiefs is a distinguished one. The list has included such men as Dr. J. Arnold Bargen of the Mayo Clinic; Dr. Louis H. Bauer, AMA trustee; Dr. Charles L. Brown, dean of Hahnemann Medical College; Dr. Thomas M. Brown of the George Washington University Medical School; Dr. Alexander Brunschwig of New York's Memorial Hospital; Dr. Garfield G. Duncan of Jefferson Medical College; Dr. Thomas M. Durant of the Temple University School of Medicine; Dr. Eugene C. Eppinger, assistant dean of Harvard Medical School; Dr. L. Kraeer Ferguson of Woman's Medical College; Dr. Reginald Fitz, assistant dean of Harvard Medical School; Dr. Marshall N. Fulton of Rhode Island Hospital; Dr. John H. Gibbon Jr. of Jefferson Medical College; Dr. Alex Gutman, editor of the American Journal of Medicine; Dr. Joseph M. Hayman Jr. of Western Reserve University Medical School; Dr. Wingate M. Johnson of Bowman-Gray Medical College; Dr. Chester S. Keefer of Boston University; Dr. Foster Kennedy of Cornell Medical School; Dr. Louis A. M. Krause of the University of Maryland; Dr. William G. Leahman of Woman's Medical College; Dr. John C. Leonard of Hartford Hospital; Dr. Robert P. McCombs of the Tufts Medical School; Dr. Alexander Marble of Harvard Medical School; Dr. Frank H. Mayfield of the University of Cincinnati College of Medicine; Dr. Jonathan C. Meakins of McGill University; Dr. Franklin R. Miller of Jefferson Medical College; Dr. Henry B. Mulholland of the University of Virginia; Dr. Maurice C. Pincoffs of the University of Maryland; Dr. William B. Porter of the Medical College of Virginia; Dr. Gerald H. Pratt of the New York Post-Graduate Medical School; Dr. I. S. Raydin of the University of Pennsylvania; Dr. William F. Rienhoff Jr. of Johns Hopkins; Dr. Hobart A. Reimann of Jefferson Medical College; Dr. Jonathan E. Rhoads of the University of Pennsylania; Dr. Edward Weiss of the Temple University Medical School; Dr. Stewart Wolfe of Cornell Medical College; Dr. Allen O. Whipple of New York's Memorial Hospital.

Dr. Read reports, "has written enthusiastically about our program."

What about financing? The matter was broached originally to leading local businessmen who were on the hospital's governing board. Impressed with the value of what was being planned, one of them—owner of the Haddon Hall hotel—agreed to take care of the visitors' hotel bills, including meals. Aside from their travel costs, visiting chiefs thus have no other major expenses.

An added talking point for Atlantic City's interne recruiting plan is the hospital's medical library, one of the most up-to-date in the country (recently the county society voted to put up $300 and the hospital staff $200 annually for additional periodical subscriptions). The Atlantic City Hospital has also arranged opportunities for its house staff to work with a nearby home for crippled children, the municipal hospital, a county T.b. hospital, and a local mental institution.

What Atlantic City has done can be duplicated by almost any hospital that can produce these ingredients:

¶ Forceful and imaginative leadership.

¶ Staff cooperation.

¶ Generosity on the part of some public-spirited business concern.

¶ Some form of visitor inducement. (This need not be limited to resort advantages. The chance to see how a new teaching method works can often be made a strong drawing card for big names.)

—J. D. OBERRENDER

factory workers and such. For each of these the Government paid him a capitation fee, while from their dependents and others he had to eke out whatever private fees he could.

Since July of last year, when the National Health Service began, virtually all his patients have been "on the scheme." He now gets a capitation fee for every one of them, including those who, before, never paid him anything. While he's now working harder than he ever did, he may also be enjoying a somewhat higher income; so his criticisms of the service are soft-pedaled.

G.P.'s in the less densely populated areas sing a different song. And they are in the majority. These are the men with suburban, small-town, and rural practices—even men in some industrial communities outside the big centers. Before the NHS, they used to do most of the private work. They had few or no panel patients. But now it's all changed. Their private work today has shrunk to a remnant. They often have only small lists of NHS patients.

Their incomes, therefore, have nose-dived. Instead of being reduced to the financial level of the panel doctor, some have dropped even below that. This come-down they've suffered, coupled with everything else, is proving to be almost beyond endurance. It explains the desire of a good many doctors to emigrate.

The irony of it is that many of the physicians who dislike the state medical service most and who have taken the worst beating financially are those with the highest standing professionally. Their colleagues whom the National Health Service has favored and who comprise the main NHS cheering section are, by and large, the more mediocre clinicians.

### *'Ruined My Practice'*

A well-known Southampton G.P. summed up his attitude in these words: "The National Health Service has simply ruined my last fifteen years in practice. I'm now 52. I wish I didn't have as many more years to go."

What private practice is left in Britain is shared mostly by specialists. A handful of those with top reputations continue to do well, but they take a dim view of the future. The majority take a dim view of the present also.

It is by now common knowledge that most British doctors are overworked and underpaid. A Harley Street surgeon remarked that "Bevan has the best slaves in the world." The big question is: How long can they stand the gaff?

A T.b. specialist in Lancashire said, "Doctors' incomes in this small town have dropped alarmingly. One practitioner here is down at least £600 ($2,400) per annum. The Socialists are killing the very

# AN OPEN FIELD for Doctors...

● Because it brilliantly illuminates and magnifies the operative field without obstruction the Arc-Vue Otoscope is invaluable to doctors when diagnosing or operating. Its simple design, rugged, lightweight construction, gives ease and freedom of action. Comfort for the patient is assured with four sizes of specula and 40° angle of declination between head and handle.

PLASTIC SPECULA, thin, strong, non-reflecting. Easily sterilized.

ROTATING SPECULUM MOUNT, 36% larger operative field.

TONGUE DEPRESSOR HOLDER.

BRILLIANT ILLUMINATION, concentrated at speculum opening.

ROTATING MAGNIFIER, 2½ magnification, giving sharp focus at orifice of speculum.

LIGHT WEIGHT... total head weight is less than two ounces.

## BAUSCH & LOMB

OPTICAL COMPANY ROCHESTER 2, N.Y.

# The most "persuasive" oral germicide you can prescribe

**1. Cēpacol persuades a wide range of oral bacteria to surrender within 15 seconds after contact[1]**

**2. Cēpacol's pleasant taste persuades your patients to use it**

The rapid antisepsis[2] and soothing relief which Cēpacol brings to inflamed, sore throats are important. Along with the fact that Cēpacol is non-irritating, non-toxic, and does not interfere with tissue healing. Too, patients are extremely grateful to you for prescribing something so effective that also is so *pleasant* to use—as either gargle or spray.

## CĒPACOL®

***The alkaline germicidal solution that works in partnership with saliva***

Merrell
1828
CINCINNATI • U. S. A.

*NOW AVAILABLE—Cēpacol Throat Lozenges! These convenient, pleasant-tasting lozenges, dissolved slowly in the mouth, provide a soothing, analgesic solution to relieve the dryness and irritation of sore throat.*

1. As shown in laboratory studies. 2. Cēpacol contains an effective germicidal detergent, the quaternary ammonium salt Cetepyn® Chloride, 1:800.

thing that has made our country great: the hope of reward."

### *Loss of Dignity*

In a letter to the British Medical Journal this summer, Dr. Harold Sanguinetti of London said, "But there are other matters even more important than pay which demand consideration by the profession and the public. I refer to the dignity of and respect for the general practitioner."

Dr. Sanguinetti was distressed by the fact that so many G.P.'s had become form fillers and traffic guides, doing little more than hand out certificates and direct patients to specialists and hospitals. "It is an insult," he said, "to a branch of the profession which in Germany produced Koch and here gave us Sir James Mackenzie. . . ."

The thing that bothers some doctors most about the NHS is the changed attitude of many patients toward their physicians. "People used to *ask* us for things; now they *demand* them," said a Welsh G.P. "We've degenerated from independent professional men to browbeaten civil servants."

Before the NHS, when a patient needed attention, he would try to see the doctor at his office. Now it's often too much trouble. So he requests a house call.

By the same token, the private patient who needed a small cut bandaged would often do it himself. The NHS patient is more inclined to go to the doctor for such

things. He reasons that he's paid his four shillings and eleven pence to the Government this week, and he wants his money's worth.

A G.P. near Exeter observed glumly that "The decent people wait too long to call a doctor. The others call all the time. The M.D. who's conscientious kills himself trying to treat his patients properly. The other fellow takes it easy and makes out financially just as well."

### *Short Cuts Deplored*

An NHS doctor practicing near Great Yarmouth was upset by the short cuts he had to take in keeping up with over-eager patients.

"Everyone who comes in," he said, "wants a bottle of medicine or a tonic. And they want one every week or two. Where I used to give a four-ounce bottle, I now often prescribe a pint. It's the only way to keep them from coming back so often. I have little enough time as it is for my really sick patients."

According to the Welsh G.P.

**Better Results**
**Added Convenience**
**Increased Economy**
**Greater Durability**
**Simplified Operation**

***GE X-Ray offers you all these advantages and***

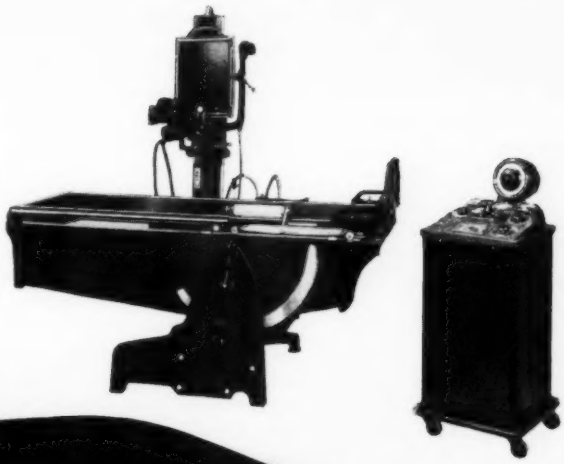
# More in the Improved 3

There is an *improved* R-39. It includes a Centralinear Control, an angulating table with built-in tube stand, a high-speed Bucky diaphragm and a Coolidge double-focus tube unit. It's *improved* from the new simplified table design to the new mobile Centralinear Control. It's *improved* from the 6-position Technic Selector to the new cassette tray which *automatically* cocks the Bucky grid.

***The new Centralinear Control.*** It automatically selects the focal spot, adjusts the space charge compensator to hold milliamperage constant, controls the filament current settings in radiography, selects the milliammeter scale, connects or disconnects the timer. A new toggle switch on the control lets you use either the push-button exposure switch or the foot switch for any technic.

***Radiography—40-inch focal-film distance.*** You can rotate the tube unit to direct radiation horizontally. A shift on the tube stand permits vertical stereoscopic radiography. The tube stand angulates with the table; the tube unit remains parallel with the table top in any position from 15 degrees Trendelenburg to vertical. Focal-film distances of less than 40 inches are easily obtained without moving tube stand and Bucky or repositioning patient.

***Fluoroscopy—only 40 seconds from radiography.*** You shift the tube unit from above to below the table in just five simple steps. Tube unit



travels crosswise 8 inches, permits full-width fluoroscopy. With the table vertical the apices of a six-foot patient are well within the 41-inch travel range of the central beam. A single-arm screen support contains the shutter control. You have a clear operating field and one hand free for palpation.

***High-speed Bucky radiography at 40 inches.*** To minimize patient film distance, the Bucky diaphragm mounts directly beneath the table top. The carriage moves freely on ball bearings for the full length of the table. A new Bucky "in and out" switch lets you control the Bucky from the control stand. When you press the exposure button, the grid releases, starts the timer and exposure, turns it off at end of predetermined exposure time.

**WRITE US** *If you're thinking of x-ray, look into the* improved *R-39 with type 5 Control. Write us for further details — and for price and delivery date. General Electric X-Ray Corporation, 4855 Electric Ave., Milwaukee 14, Wisc.*

**GENERAL ELECTRIC**
**X-RAY CORPORATION**

General Electric X-Ray Corporation manufactures and distributes x-ray apparatus for medical, dental and industrial use; electromedical equipment; x-ray and electromedical supplies and accessories.

quoted, "People are losing their sense of responsibility. The old doctor-patient relationship is fading fast. In ten years the doctor won't care what the patient thinks of him—only what the Health Ministry thinks of him."

This transfer of the NHS physician's allegiance from the patient to the state has been mentioned also in a letter from Dr. H. A. H. Harris of Chelmsford, England, to Dr. Wemple Dodds of Crawfordsville, Ind.

Dr. Harris' letter, published recently in the Congressional Record, states that "Our future doctors will be small-minded little men with civil service mentalities. Their main concerns will be keeping on the right side of their administrative superiors, filling forms correctly, watching the clock, and passing the buck."

Much professional alarm over the National Health Service arises from the belief that it will in time reduce every doctor to the same stratum of mediocrity. The only opportunity left under those circumstances will be the opportunity for a low-level personal security.

Unfortunately, this prospect does not deter a good many British doctors of indifferent ability. These men exhibit little of the old-fashioned will-to-get-ahead. First they became resigned to the system, now they actually welcome it as an easy way out. Many are tired out from the war, austerity living, and the staggering demands of their NHS practices. The fight has been sapped out of them. [*Turn the page*]

## The Next Voice You Hear . . .

● I was using the facilities of the university's ob./gyn. clinic to make some electroencephalographic studies of uterine motility. The psychiatry department warned me that the machine wasn't too well insulated, but said it should serve my purpose. I rigged up a set of special electrodes for attachment to the cervix and selected as my first subject a young colored girl. After getting the experiment set up, I could see the recording was going beautifully, so I stepped out to the corridor for a smoke. A moment later a shriek from the patient brought me back on the double. "Doctor," she quavered, "they're talking from my womb!"

The girl was obviously imagining things. However, to humor her, I bent over to listen. To my astonishment, a muted voice emanating from her vulva announced, "Ladies and gentlemen, you are tuned to the Nation's Station." —N. S. ASSALI, M.D.


***The fluid sulfadiazine that***

Children—and adults who balk at bulky sulfadiazine tablets—take ESKADIAZINE willingly because of its delicious taste and pleasant consistency.

Instead of ordinary sulfadiazine, ESKADIAZINE contains S.K.F.'s *microcrystalline* sulfadiazine in a stabilized suspension. Result: desired serum levels may be attained *3 to 5 times more rapidly* with ESKADIAZINE than with sulfadiazine in tablet form. Each 5 cc. (one teaspoonful) contains 0.5 Gm. (7.7 gr.) of sulfadiazine—the dosage equivalent of the standard sulfadiazine tablet.

***Smith, Kline & French Laboratories, Philadelphia***

# *Eskadiazine*

***the outstandingly palatable fluid sulfadiazine***

One such doctor, queried about his plans for the future, said, "Plans? What plans? I have none. I just hope I can stay in the groove I'm now in. It may be hard for you to understand this; but after what we've been through, I'm glad just to be alive."

There's another factor also: Many of Britain's doctors had a long period of conditioning to state medicine. Under the Government's panel system that operated from 1911 to 1948, they took care of the medical needs of 40 per cent of the people. To these M.D.'s, Government methods and terms of practice are old hat.

### *No Incentive*

Doctors who used to do mostly private work and who had few panel patients are the ones who now feel most apprehensive about the threat of regimentation. An obstetrician in Shropshire said, "Under the NHS, one is no longer a free agent. One must bend to the dictates of administrative committees.

"Bureaucratic interference is increasing all the time. This makes not only for irritation but for frustration—and that's what kills incentive. We've gotten into the present mess by putting our security ahead of our freedom. In the process, we've undermined the best interests of ourselves and our patients."

### *Abuses of Scheme*

Besides objecting to the health service on broad grounds, doctors cite a variety of more detailed complaints. High on the list of these is the multitude of trivial cases the scheme tends to breed.

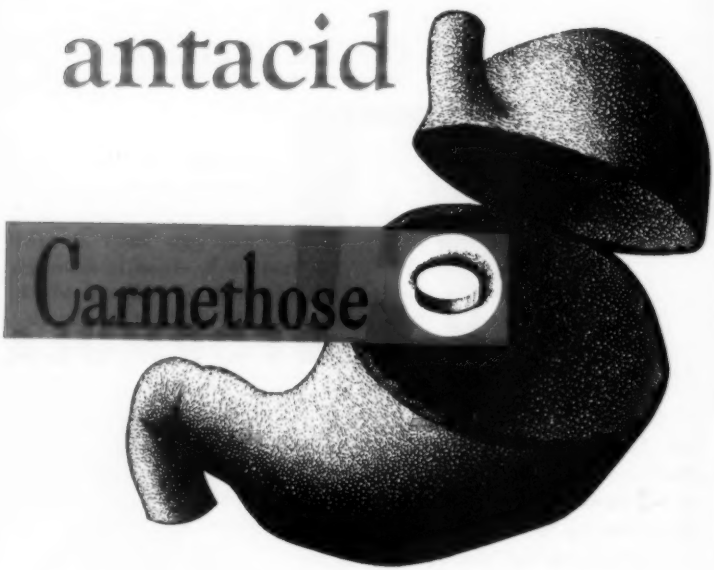
According to a Liverpool G.P., "I get so many trivial calls that the serious ones must sometimes wait. From the descriptions over the phone I can't always tell, of course, which cases are urgent and which are not.

"Just yesterday I received a call that a patient needed me and would I please come over as soon as possible. When I got to the house, she was out for a stroll."

A country doctor near Inverness, Scotland, had had a similar experience: "The other afternoon I got a call to visit a patient who lives about five miles from here. I hurried out to her place at the first opportunity to find out what was wrong.

" 'It's this bunion,' she said. 'I began to be troubled by it a fortnight

# New type antacid




# for better management of peptic ulcer

# Carmethose gives prolonged control with no adverse effects . . .

Carmethose promptly lowers gastric acidity,  and its protective tenacious coating  has been observed in the stomach for as long as three hours.[2] 

**Advantages over adsorbent gels:**

1. *Non-constipating*—hydrophilic gel promotes normal elimination.[1,2]
2. *Reduction of acidity in two ways*—prompt action by ion exchange is followed by classical buffering action.
3. *Palatable*—small, easily swallowed tablets and pleasantly flavored liquid—preferred by patients.[2]

**Advantages over soluble alkalis:**

1. *No acid rebound*—effectively inhibits acid-pepsin activity, with no secondary hypersecretion.
2. *Protective coating*—mucin-like gel is rapidly formed and clings to ulcer crater and gastric mucosa.
3. *Non-systemic*—cannot disturb acid-base balance because it is non-absorbable.

*Adult dose 2 to 4 tablets or teaspoonfuls 4 times daily between meals.*

*1. Brick, I.B.: Amer. J. Dig. Dis.,* In Press *2. Bralow, Spellberg & Necheles: Scientific Exhibit #1112, A.M.A. Ann. Sess. 1949*

Carmethose Tablets: Sodium carboxymethylcellulose, 225 mg. and magnesium oxide, 75 mg. Bottles of 100.
Carmethose Liquid: 5% concentration of sodium carboxymethylcellulose. Bottles of 12 oz.

Ciba

PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

CARMETHOSE—Trade Mark

2/1504M

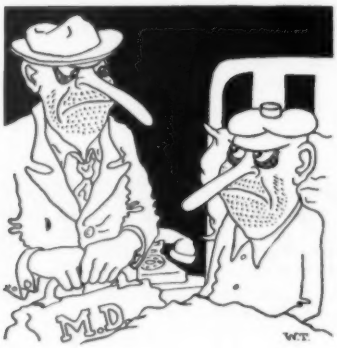
ago. Do you think I need a surgeon to remove it?' "

Another doctor in the same district said "This is the heyday of the neurotics. They've seized the chance of a lifetime to glorify their ailments—at public expense!"

Not all practitioners report abuses of the system, but the number who do are in the majority. They're particularly irked—as any citizen might be—by the gross waste of public money.

They mention, as examples, the many people who get spectacles without needing them: those who demand glasses to "preserve" their eyesight, those who want a pair because they think they look better in them. They also mention the women who come in to get "free" corsets for obesity. The prize case cited was that of the balding male patient who, rather than buy a hat, asked his doctor for a "free" wig to keep his head warm.

A number of doctors, in common with their patients, feel that the Government, through its National Health Service, attempted too much in too short a time. Not only has the quality of medical care deteriorated as a result, they say, but a number of proposed features of the scheme have gone by the board—*e.g.*, the program of preventive medicine.




### '*Not for* My *Son!*'

The real payoff in this matter of how doctors view the NHS is found in their answer to the question, "Would you advise a son of yours to go into medicine now?"

Most said no.

A G.P. in Wales remarked, "My father was in practice here for forty-six years. I've been at it since 1933, except while in service. I had hoped my son might carry on after me; but I'm now advising him to make a career in another field.

"Things have reached the point where a young man may well ask, 'Why should I spend seven or eight years studying to practice medicine at, say, £800 ($3,200) a year when I can make as much in another field with one-third the training—and not have to resign myself to the status of a civil servant?' "

The Chelmsford surgeon quoted said, "My general practitioner friends are now, without exception, unhappy men. Pride in their job is waning. I know of none who are bringing up their sons to follow in their fathers' footsteps."

—WILLIAM ALAN RICHARDSON

# *PROGRESS REPORT ON NEW ANTIANEMIC AGENT*

IN 1946, observers[2,3] noted that striking results could be expected from the treatment of hypochromic anemia with molybdenized ferrous sulfate (Mol-Iron).

Subsequently a two-year investigation[4] of Mol-Iron was initiated in anemia of pregnancy—a relatively resistant type of anemia.

The investigators, Chesley and Annitto, working at the Margaret Hague Maternity Hospital, reported:

> "... molybdenized ferrous sulfate produced a substantially more rapid therapeutic response than ferrous sulfate, the difference in response being statistically significant. Addition to ferrous sulfate of either liver-stomach extract or folic acid did not potentiate the action of the iron salt."

***REFERENCES:***


1. Dieckmann, W. J., and Priddle, H. D.: Anemia of Pregnancy Treated with Molybdenum-Iron Complex, American J. Obstet. & Gynec. 57:541-546 (March) 1949.

2. Healy, J. C.: Hypochromic Anemia: Treatment with Molybdenum-Iron Complex, Journal-Lancet 66:218-221 (July) 1946.

3. Neary, E. R.: Use of Molybdenized Ferrous Sulfate in Treatment of True Iron Deficiency Anemia of Pregnancy, Am. J. M. Sc. *212*:76-82 (July) 1946.

4. Chesley, R. F., and Annitto, J. E.: Evaluation of Molybdenized Ferrous Sulfate in the Treatment of Hypochromic Anemia of Pregnancy, Bulletin of the Margaret Hague Maternity Hospital *1*:68-75 (Sept.) 1948.

5. Kelly, H. T.: Gastro-Intestinal Intolerance to Orally Administered Iron, Pennsylvania M. J. 51:999 (June) 1948.

*"Results with . . . molybdenum-iron complex . . . striking . . . increases in hemoglobin . . . dramatic . . . rapid . . ."*[1]

Now Dieckmann and associates[1], following extensive controlled studies in pregnant patients, state:

> "We have never had other iron salts so efficacious in pregnant patients. . . Our results with the molybdenum-iron complex have been . . . striking . . . increases in hemoglobin were . . . dramatic and . . . rapid . . ."

—And Mol-Iron is remarkably well tolerated. Typical of the findings of other investigators, Kelly[5] reports that 90% of his test patients who had previously been unable to tolerate other iron preparations were satisfactorily maintained on molybdenized ferrous sulfate.

**White's Mol-iron Tablets, Liquid**

**MOLYBDENIZED FERROUS SULFATE**

a specially processed, co-precipitated, stable complex of molybdenum oxide 3 mg. (1/20 gr.) and ferrous sulfate 195 mg. (3 gr.). Recommended adult dosage: 2 tablets, t.i.d. Available in bottles of 100 and 1000 Tablets and in a highly palatable Liquid, in bottles of 12 fluid ounces (each teaspoonful equivalent to one Tablet).

**WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N.J.**

vertiser intimates that the normal situation is for everyone to leap out of bed at the first hint of dawn and face the world with bared teeth. His man leaps out with uncreased pajamas and his woman with her hair-do as perfect as when she left Pierre's. Anything else is not natural and should be investigated.

Reluctance to abandon the sheets may be due to a lazy colon. Note that it's not the patient who is lazy, but his colon. (In the ad world, incidenally, no one ever suffers from diarrhea.)

Two favorite leitmotivs of the adman's opera are these: First, his products are fundamentally *natural*—even if they sometimes have to be spelled backwards. Second, the prospective patient is encouraged to blame some uncooperative organ rather than himself for his shortcomings.

A variation on the cathartics theme is the diuretics theme. Diuretics are usually for the person with backache. Also, for anyone who wishes to get rid of poisons. To be sure, these poisons are not bad enough to see a doctor about. But what person would knowingly go around with a tankful of poison?

Some people who find it difficult to swallow pills have proven reluctant to take the mere two or three dozen that would put them on an even footing with Superman. For them, nature foods have been created. A teaspoonful of Herbpep, for example, in a glass of milk, with an egg and some beef juice, will give more thiamin than a bucket of cement, more calories than a cubic yard of sea water.

According to the advertisements, everyone today is living at the rate of a hundred-yard dash. Energy is the *sine qua non*. Science (another leitmotiv) teaches us that the body burns glucose to produce energy. What better equipment could there be for the race track of life than an O. Wilbur candy bar? If your child sits in a corner and if grandpa can't make the basketball team, it is only because they don't know the power that awaits them in this tasty, tempting tidbit.

### *Soap is Eternal*

Yet the ad world poses its problems. Shall a sensitive woman choose soap *A* and have a lovelier skin? Or soap *B*, preferred by nine out of ten screen stars? Soap is more specialized than the medical profession. There is one for the face, one for the hair, one for the shower, one to prevent the hands from looking like lobsters or dish pans. There is also one that causes matrimony.

Beauty may be only skin deep, but billboard medicine never paints the situation that simply. The adman can picture a devastating chain of events that leads from a low yeast count in the stool to spinsterhood via a sluggish epidermis and not being asked to the dance. Similarly, the road to success for those whose ovaries have failed is

paved with facial creams to which estrogens have been added.

Dandruff may be considered a mild form of scalp cancer. Each hair is a vibrant, living thing. Being bald is funereal, and having that dull, lifeless texture is tantamount to being at death's door. The hair should glow like a neon light. On the male head, it should stay in place. Only doctors giving advice on toilet tissue are permitted to be grey or bald. Other ad models are required to give themselves a tingling, two-minute rub.

### *Odor? Oh Yes!*

It is the adman's contention that you should smell like a woman being kissed by a violinist (feminine approach) or like a pine tree (masculine approach). Ordinary cleanliness is not enough. The only sure sign of correctness is to smell of the advertiser's product. With care, you can, in fact, be an olfactory symphony, depending on what you put behind your ears, on your hair, and on your face; what you wash your mouth and brush your teeth with; and what you slap under your arms and on your torso. Perfume advertisers do not carry their commands below the umbilicus.

The teeth are subject to maladies never encountered in the textbooks of oral pathology. There is, for example, the film which changes a girl from a Betty Grable to the witch in Snow White. The pharmacology of dentifrices has some remarkable aspects, too. One preparation allows the teeth to be cleaned in fifteen instead of twenty seconds. Another has alkaline properties which aid in gall bladder dysfunction.

Bacteriological advertising is not so fashionable as it used to be. The germ theory of indisposition has given way to the psychosomatic view of social failure. Anyhow, everyone knows that nowadays penicillin stops every germ stone dead.

Of course, we still suffer such things as headaches—of which there are three principal kinds. First, there's the one that your lady love pleads when you show up for a date after shaving with an inferior cream. Another is the kind that persists and you should see your doctor about. Finally there's the one that does *not* persist, for which you might as well use the advertiser's product. Your choice of remedy will be determined by what gimmicks intrigue you. One product makes an interesting bubbling sound; another will disintegrate before you'd hit the ground from a fifth story window; a third acts in a dozen different ways at the same time, assuring you all the internal activity of an electric washer.

There is a quaint syndrome characterized by a little green man poking pitchforks into your arms and legs. And another in which the toe of your shoe has to be cut away to expose smoking feet. In the same category is the biceps muscle that

# Clinical tests prove that PRO-CAP is less irritating

"141 patients, including the 130 developing adhesive irritations of various degrees, were then exposed to the adhesive tape containing the fatty acid salts. The plaster was used 970 times on these patients. Only 5 patients developed irritations which were sufficient to cause complaint. The irritation even in those instances was not sufficient to warrant discontinuation of the use of this new plaster."

—R. E. Humphries: New Factors in Adhesive Formulas Which Lessen Irritation. J. Investigative Derm. 9:219-220 (Nov.) 1947

**SEAMLESS PRO-CAP ADHESIVE PLASTER**

SOLD THROUGH SURGICAL AND HOSPITAL SUPPLY DEALERS

## THE ONLY ADHESIVE CONTAINING FATTY ACID SALTS

Seamless PRO-CAP is a superior quality Adhesive Plaster containing zinc propionate and zinc caprylate—two medically-proved ingredients. PRO-CAP provides these *three* important advantages, *at no increase in price!*

- **Skin irritation and itching are substantially eliminated.**
- **PRO-CAP adheres better. Less slime and maceration to interfere with tackiness.**
- **PRO-CAP can be left on the skin or renewed over longer periods, with little or no skin reaction.**

RESULT: More comfort for your patient . . . Less interference with your treatment . . . We invite you to discover PRO-CAP's outstanding qualities in your own practice. Write for illustrated brochure and reprints of medical reports.

*FINEST QUALITY SINCE 1877*

SURGICAL DRESSINGS DIVISION

**THE SEAMLESS RUBBER COMPANY**

NEW HAVEN 3, CONN., U. S. A.

SR SEAMLESS

has been separated from its attachment, tied in a knot, and then reattached.

Of interest to the otolaryngologist is the discovery of a T-zone. Anatomically, this is a rather ill-defined region conforming in part to the oropharynx and sensitive to all but one variety of nicotinic inhalant.

The copy writers always imply that, with their products, you are as good as under a physician's care. Their nostrums are compounded by specialists, resemble a prescription, and are used by eight out of ten doctors. These wares have virtues confirmed by laboratory tests and verified at the largest hospitals. The ingredients have either been tried and found true for the past 173 years, or they include that newest scientific wonder, trihydoxy-formaldehyde, popularly known as crystal moonbeams. Some of the more delicate products are advocated confidentially by nurses.

From cradle to crypt, life is one ad crisis after another. As an infant, you are too delicate. As a child, you struggle for the hero role by eating the proper snapping, crackling grain. In adolescence, your epidermis makes a wall flower of you. In your twenties, you can count on athlete's foot, halitosis, and B.O. Still, the climax is not yet. That comes when the fellow with the pince-nez points his finger at you and asks grimly: "Are *you* past *thirty-five?*"

—THEODORE KAMHOLTZ, M.D.

# Higher Fees for Life Insurance Exams

***The AMA opens a drive to raise the rates paid for medical exams and reports***

● Long a sore point with M.D.'s have been the low fees paid by most life insurance companies for medical examinations and for physicians' reports. At its meeting in June, the AMA launched a campaign to hike these payments. The House of Delegates, mulling a report by the association's Bureau of Medical Economic Research, voted to forward copies to state and local societies for their use in direct negotiation with insurance concerns.

Any fee agreement between the insurance companies and the AMA itself, it was noted, might run afoul of the anti-trust laws. So the association is passing the ball to its component societies.

The AMA report is based largely on a questionnaire survey of insurance concerns conducted by the Association of Life Insurance Medical Directors. Some 153 companies, doing 92 per cent of the life insurance business in the United States, are covered. The report indicates that 85 per cent of these pay a standard $5 fee for a long-form exam. Nearly all the rest —mostly larger companies—use a sliding scale that ranges from $5 up to $10 or $15, depending on the size of the policy. There's less standardization of payments for attending physicians' statements, though 69 per cent of the companies pay a flat $2.

AMA also lists local medical societies that have passed or are considering resolutions favoring an upward adjustment of life insurance fees. These include Rhode Island Medical Society; Tennessee State Medical Association; Oregon State Medical Society; Medical Society of New Jersey; Colorado State Medical Society; Idaho State Medical Society; Utah State Medical Society.

### *No Success Yet*

Some of these organizations favor upping the examination fee to $7.50, others to $10. Some say attending physicians' statements are worth $3, some say $5. But, says the AMA, "None of these societies which have passed resolutions reports any adjustment in fees as a result of the resolutions." Evidently that's going to require a few man-to-man sessions with the insurance companies. —HENRY O. PETRY

**Gives the cough relief your patient wants...**

**Leaves the cough reflex he needs**

In the average case, it's usually possible to control the patient's cough—but often it's a real problem to do it without impairing the cough reflex he needs to keep bronchioles and throat passages clear. That's where you'll find pleasant-tasting Mercodol unique!

For Mercodol contains the cough-controlling narcotic[1] that gives better antitussive action than codeine or heroin, yet keeps beneficial cough reflex . . . a superior bronchodilator[2] to relax plugged bronchioles . . . an effective expectorant[3] to liquefy secretions. And you'll find Mercodol notably free from nausea, constipation, retention of sputum, and cardiovascular and nervous stimulation.

# MERCODOL®

**AN EXEMPT NARCOTIC**

*The antitussive syrup that controls cough—keeps the cough reflex*

Merrell
1828
CINCINNATI • U. S. A.

Each 30 c.c. contains:
[1]Mercodinone* 10.0 mg.
[2]Nethamine® 0.1 gm.
[3]Sodium Citrate 1.2 gm.
*Trademark.

## What They're Reading

### ARTICLES

MY COLLEAGUE, THE INDIAN MEDICINE MAN. By Joseph H. Peck, M.D. Humorous and hectic account of what it's like to practice on an Indian reservation with the local medicine man looking scalping-daggers at you for poaching on his domain. Saturday Evening Post, July 2.

### BOOKLETS

WHAT ARE WE ARGUING ABOUT? Sorts out and defines the welter of terms that usually come up in a discussion of compulsory health insurance. 11 pp. American Dental Association, Chicago. Gratis.

### BOOKS

SIAM DOCTOR. By Jacques M. May, M.D. A French surgeon has some hair-raising tales to tell about the strange cases and characters he encountered in a snake-infested, semi-barbarous land. 255 pp. Doubleday & Co., New York. $2.75.

MEDICINE ON THE MARCH. By Marguerite Clark. A résumé by Newsweek's medical editor of the profession's most recent advances. 308 pp. Funk & Wagnalls Co., New York. $3.50.

# The Newsvane

## Country Doctor Scores Give-Away Spree

The St. Louis Post-Dispatch has received a bunch of scallions from a reader who signs himself "Country Doctor." He writes: "Now that you are loudly beating the drums for compulsory health insurance, why not for other forms of insurance? How about home-repair insurance? Then, when the roof starts to leak at 11 P.M., one can call the carpenter and demand that he come at once and repair it. Consider legal insurance. If Aunt Liza goes to her maker at 2 A.M., one can call the lawyer and demand that he come at once and read her will. How nice it would be to have food insurance so one could go into a grocery and carry out food by the armful. Let's have travel insurance, shoe insurance, etc. Then we can call Joe Stalin 'Brother' instead of 'Uncle.'"

## Can't Search Innards Without a Warrant

It's illegal to rummage around inside a man without his permission or a search warrant, says Federal Judge W. H. Atwell of New Orleans. Ruling in the case of one August Guzzardi, from whose stomach had been pumped several grains of heroin, the judge said: "If a man's home is sacred against illegal search, certainly no one can say that a man's body is not just as sacred."

Brow-beating detectives had pumped the Guzzardi gizzard against his wishes. However, the judge ruled the evidence, though illegally obtained, was admissible in Federal court, since the pumping job was not ordered by a Federal agent.

## Warns Against Killing Golden Goose

If doctors want to guard the goose that lays the golden egg, they'll think twice before pulling stakes and moving their practice to another town. This is the opinion of syndicated health columnist Dr. George W. Crane, author of the "Worry Clinic." Says Dr. Crane: "It has been estimated that a dentist or physician must treat at least 500 patients before his practice is large enough to make him a comfortable living. And he needs to treat 800 before he is rushed with patients."

Dr. Crane points out that the

doctor who leaves his practice to move to another city is compelled to start all over again to build up patronage. "Too many professional men," he says, "have succumbed to the lure of California or other publicized spots only to find later that something went wrong. The golden goose of professional men is the first 500 satisfied customers. They feed future patients to you."

## Hits Evils of Subsidy System

AMA Trustee Dr. Walter B. Martin told a house subcommittee that he favored more funds for school health programs, but opposed Federal control in the administration of the national school health service bill. "The Congress," he said, "should lay down broad general controls in the bill. The only necessary administrative controls should be a proper audit of funds to determine that they have been honestly administered."

In Dr. Martin's opinion, "The whole question of Federal subsidy and of the partition of tax resources between the Federal, state and local governments needs to be re-examined and re-evaluated. The flow of the major fraction of our tax money into the Federal treasury and its distribution to the several states in subsidies is a dangerous procedure. If not properly safeguarded, it threatens the security of our form of government."

He points out that the tax re-

sources of municipalities and states have become so depleted that they are unable to carry out needed projects without Federal aid. "The evil of this becomes apparent when we see Federal subsidy used as a club to compel the adoption by the states of certain procedures not at the time acceptable to all of the states, and at times contrary to their political and moral philosophy, and even their laws."

The doctor warns, "Federal control to a greater or lesser degree follows the distribution of Federal subsidy. Since these funds are appropriated from the Federal treasury, it is assumed that some form of Federal administration and control must be set up." He rejects the idea that a Federal administrator is wiser or more honest than state administrators. This notion, he says, reverts to the old, undemocratic theory that "some special virtue resides in the administrator of the supreme government."

## Puzzled by Doctor Who Won't Send Bill

Emily Post charts a course of action for the patient whose doctor refuses to send a bill. "We called a doctor on an emergency," writes the patient, "and liked him so much that we'd like to have him for our family doctor. We've asked several times for his bill, but he answers that he was glad to do it."

Advises Mrs. Post: "Explain frankly that you would like to be-

come a regular patient and you couldn't do this unless he sends you a bill. If he says he will send a bill next time, you can feel free to call on him when you again need his advice. If he then sends no bill, go to another physician."

## Three-Year Residency Designed for G.P.'s

Pioneering in the field of G. P. education, the University of Colorado now offers a special three-year residency for the training of general practitioners. Says Dr. Frode Jensen, director of graduate and postgraduate education at the university's medical center: "It is now recognized that more than the customary four years of undergraduate medical education and an internship are necessary to prepare a man for practice, regardless of the field." Candidates for the training program must have completed an approved one-year internship.

The Colorado course is adapted to the type of work G.P.'s are required to do in rural Rocky Mountain areas. The first year is divided between a study of general and psychosomatic medicine and pediatrics. In the second and third years the curriculum may be juggled according to the trainee's bent, but a year of general surgery and four months of ob-gyn are recommended. To complete his training the resident serves four to six months with a rural hospital. The country-hospital plan is also

# UNIFORMITY


One of America's finest drug plants is devoted solely to the making of Bayer Aspirin. Nothing you prescribe is more carefully made. To make sure that Bayer Aspirin is always uniform in quality, more than seventy tests and inspections are employed in its manufacture. Behind these tests and inspections are forty-seven years of experience in making *the* analgesic for home use . . . Bayer Aspirin.

intended to encourage residents to take up practice in rural areas where physicians are needed.

About two dozen beginner G.P.'s are now enrolled in the program. Their duties and status are that of junior residents. So far, courses have been conducted by specialists, but eventually the university hopes to have general practitioners on its teaching staff.

## Doctors Pay Hospital 'Cover Charge'

Somewhat in the manner of night-club patrons, staff members of the Norwood Hospital, Norwood, Va. (population: 16,000) pay a "cover charge" for each patient they bring to the hospital. Physicians are billed $1 for each child who has tonsils or adenoids removed and who stays overnight. The fee for medical admissions is $3, for surgical cases, $5. During the plan's two years in operation, the hospital's seventy-one staff members have been taxed a total of more than $20,000. The six busiest doctors have contributed over $1,000 each. The hospital plans to cancel the tax when receipts reach $60,000.

## Raps Restrictions on Hospital Practice

Is it ethical for a hospital to solicit contributions from Joe Public with one hand while restricting the professional activity of his physician with the other? A case in point, says Dr. William Bromme, editor-in-chief of the Detroit Medical News, is the recent action of the executive committee of Detroit's Mount Carmel Mercy Hospital. Mount Carmel has stipulated that fractures be treated only by orthopedists, genito-urinary surgery performed only by genito-urinary surgeons.

"As a member of the latter group," says Dr. Bromme, "I might suggest that if anyone wants a monopoly on neonatal circumcisions, he can have it without comment by the rest of us. Were the premise in these regulations developed further, one could expect that obstetrics would be funneled into the exclusive purview of the obstetrician, the indirect inguinal hernia into one surgeon's gloved hand and the direct inguinal hernia into another's, and that the drawing of blood be left to the exclusive jurisdiction of the leech!"

## Townsendites Organize Political Party

At their recent national convention, 5,000 Townsend Club delegates launched a new political party. Its aim: "Abolition of poverty in America." The Government, they feel, should pay everyone aged 60 or above an average pension of $156 a month. Delegates applauded for ten minutes when 83-year-old Dr. Francis E. Townsend, founder-president of the Townsend Clubs, rose to read the resolution:

"In view of the evident lack of

ability on the part of both the Democratic and Republican parties to provide our nation with such insurance, we, the delegates of the ninth national Townsend Plan convention, declare it our intention to establish a new political party dedicated to the task of establishing and maintaining such national insurance, and to take such steps as are needed to legally establish such party."

The House Ways and Means Committee now has pending a bill to set up the Townsend plan. Funds would be raised by a 3-per-cent tax on business incomes and salaries above $250 a month.

## Heart Report Draws Fire

A report suggesting that diet is the most important way to decrease hemoglobin and prevent coronary occlusion has met with vigorous objections on two counts. The paper, written by Dr. Ernest Klein and published in the journal of the Medical Society of the County of New York, was criticized from a scientific viewpoint by heart specialist Dr. Robert L. Levy: "The conclusion that 'coronary thrombosis may be avoided by regular hemoglobin examination' is ridiculous."

The other objection comes from Drs. Edward M. Bernecker and John H. Mulholland, administrator and medical board chairman, respectively, of Bellevue's University Hospital. They claim that the

**30-DAY TEST REVEALED**

# *"Not one single case of throat irritation due to smoking CAMELS!"*

Yes, that's what throat specialists reported after making weekly examinations of the throats of hundreds of men and women from coast to coast who smoked Camels, and only Camels, for 30 consecutive days.


*According to a Nationwide survey:*

## *More Doctors Smoke CAMELS*

*than any other cigarette*

Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

author, although connected with the hospital's blood and plasma division, had not obtained its approval of the report. "The university rules of publication," they say, "were inadvertently unheeded." Dr. Klein was subsequently dismissed from the staff. He asserts that he was dismissed without a chance to present the facts he had gathered in three years of research work.

## Law Hampers Use of Physical Therapy

Signs are that the New York State law governing the practice of physical medicine is due for stricter enforcement. Under the law, passed in 1926, physical therapists are the only non-medical personnel who may administer physical medicine other than in hospitals. A registered physical therapist is defined as one who, after adequate preliminary education, has taken a four-year course in physical education and therapy.

Unless the doctor's assistant is a trained nurse or a registered physical therapist, it's against the law for her to handle any of his physical therapy apparatus. If the assistant turns on a short-wave machine, or even reduces the intensity of application, the doctor stands to receive a reprimand or possibly to lose his license. The situation is complicated by the shortage of nurses and the fact that in the entire state of New York there are only 200 registered physical therapists. The prospect for an increase in the latter is slight, since only schools giving full four-year courses may teach any phase of physical medicine except massage.

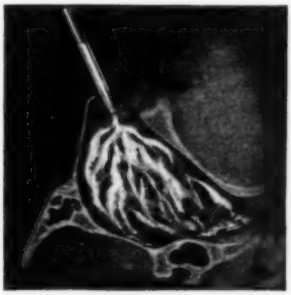
There's some demand to amend the law. But fear is that unless M.D.'s take a hand, the amendments may only serve to hamper further the doctor's use of physical therapy equipment.



## Speakers Supplied With Ready-Made Notes

To give speakers a hand in presenting the facts on compulsory sickness insurance, the Illinois State Medical Society has printed in quantity a pocketsize, loose-leaf file of speaker's notes. The society points out that the cards alone don't

# For drainage and bacteriostasis in sinusitis



You get both drainage and bacteriostasis when you prescribe Paredrine-Sulfathiazole Suspension.

The Suspension's vasoconstrictor—'Paredrine Aqueous'—shrinks the mucosa and opens sinal ostia and ducts. Drainage is promoted.

The Suspension's Micraform sulfathiazole spreads rapidly in a fine, even film over the turbinates and throughout the nasal meatuses. Bacteria are neutralized before they can enter the sinuses and intensify the infection.

*Smith, Kline & French Laboratories, Philadelphia*

***vasoconstriction in minutes***

***bacteriostasis for hours***

**Paredrine-Sulfathiazole Suspension**

constitute a speech. They rather suggest ideas and furnish a handy point of departure for whatever arguments the speaker wishes to stress and develop. The notes are arranged in quickly readable outline form, provide pertinent data on the history and details of compulsory health legislation, and the AMA counterproposals. Speakers are also primed on what questions to expect from the audience and supplied with the necessary ammunition for answering.

## Says Permanente Plan Offers Top-Rate Care

Henry Kaiser, president of the Kaiser-Permanente voluntary hospital and medical service plan, has marshaled facts and figures to refute critics and to prove that K-P care and its method of operation are top-notch. Serving about 100,000 subscribers (only 12 per cent of them Kaiser employes), the Permanente plan has hospitals and

## *Anecdotes*

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

# Infant skins treated with lotion*were smoother . . . softer . . . exhibited fewer irritative rashes

(as reported in American Journal of Diseases of Children)

**In evaluating** the effectiveness of certain preparations for infant skin care, 2077 newborn infants were observed in a large Chicago hospital.

Over a two-year period, Johnson's Baby Lotion was used for routine skin care. Incidence of miliaria showed a dramatic drop from a high of 55% (before use of lotion) to a low of 3% (with lotion care).

Johnson's Baby Lotion is specially formulated to agree with infant skin. A homogenized oil-in-water emulsion, it leaves a discontinuous film, permitting normal heat radiation and allowing free transpiration of insensible water loss.

***Available commercially as**


**JOHNSON'S BABY LOTION**

Johnson & Johnson

***FREE! Mail coupon for 12 distribution samples!***

Johnson & Johnson, Baby Products Div.
Dept. E-5, New Brunswick, N.J.

*Please send me 12 free distribution samples of Johnson's Baby Lotion.*

Name_____

Street_____

City_____ State_____

*Offer limited to medical profession in U.S.A.*

# Aids to more effective

## 5 DO'S AND DON'T'S FOR CORRECTING CONSTIPATION

A useful guide for distribution to patients, this tested set of rules serves as a daily reminder of "what the doctor ordered." While stressing rational correction of constipation under the physician's direction, it also emphasizes important guides for healthful living valuable in most therapeutic regimens.

**5 DO's and DON'T's,** in pads of 25 leaflets, are available to you on request. These leaflets contain no advertising.

**SARAKA®** **SUPERIOR BULK-LUBRICANT**

smooths the way to normal bowel function. It forms soft, smooth, demulcent bulk to provide physiologic stimulus to colonic action.

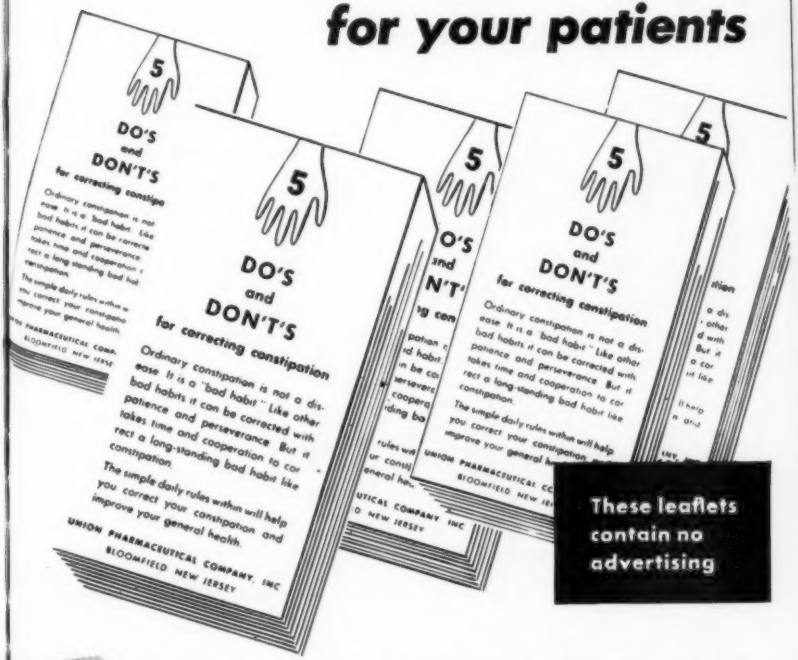
**SARAKA'S** unique vegetable hydrogel, bassorin, is non-absorbable, releasing no irritant end-products as may occur with psyllium derivatives. SARAKA does not interfere with absorption of fat-soluble vitamins which may occur with mineral oil. A simple palatable dosage schedule and effective relief within 24 hours assure gratifying cooperation when SARAKA is prescribed.


**SARAKA'S** distinctive properties offer significant advantages in the management of constipation.

UNION PHARMACEUTICAL CO. INC., BLOOMFIELD, N. J.

# management of constipation..

## for your patients




**These leaflets contain no advertising**


*Union Pharmaceutical Co., Inc.*
*Bloomfield, N. J.*

*Please send me*

25 sets of instructions for my patients—the "5 DO's and DON'T's For Correcting Constipation"
and
a clinical supply of SARAKA for 3 patients.

NAME_____ M.D.

ADDRESS_____

CITY ZONE STATE

clinics at Oakland, San Francisco, Richmond, Vallejo, and Fontana, Calif.; Portland, Ore.; and Vancouver, Wash.

A major feature of the plan is that its doctors practice as a group, using the medical-center facilities of the non-profit foundation operating the plan. "A large percentage," says Kaiser, "are partner-owners of their own practices. New additions to the staff of physicians and surgeons become eligible to join the partnership after a period of service with the organization."

The prepaid funds are divided between Permanente hospitals and the medical group according to the services provided by each. Doctors, says Mr. Kaiser, prosper under the plan: "On the basis of surveys by Medical Economics, it is found that Permanente doctors receive earnings at least equal to or better than the averages for individual practicing doctors in their various fields." The physician group employs its own assistants, nurses, etc. The doctors lease space in the medical centers, while the hospitals pay expenses out of their share of the funds.

The following facts and comments, Mr. Kaiser says, attest to the quality of medical care offered by the plan:

¶ The American College of Surgeons has accorded full approval to the Permanente Foundation Hospital in Oakland.

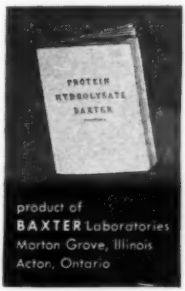
¶ The AMA Council on Medical Education and Hospitals has approved Permanente Hospital for

*Announcing*

**an aid to**

# Sedation


**Many investigators have reported the value of parenteral alcohol in operative cases as a sedative and analgesic, substituting for opiates and so eliminating undesirable side effects. In introducing this solution of 5% Protein Hydrolysate w/v, 5% Dextrose w/v, and 7.5% Alcohol v/v, Baxter Laboratories offer a single solution which provides protein nourishment, caloric value and sedation.**




*Write today for 16-page booklet giving detailed information on Protein Hydrolysate, Baxter.*

**protein and caloric requirements with minimum fluid infusion** In many cases where nutrition must be provided parenterally, it has been difficult to provide sufficient calories without too much fluid. In addition to its analgesic value, this solution provides a richer available source of energy than dextrose and protein digest solutions. Each 1000 cc. provides 800 calories.

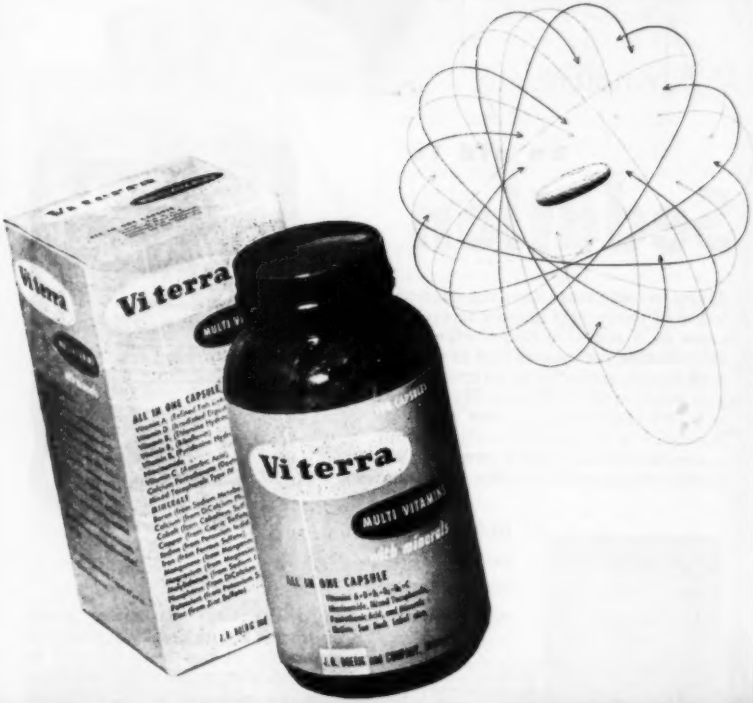
*Distributed and available only in the 37 states east of the Rockies (except El Paso, Texas) through*

**AMERICAN HOSPITAL SUPPLY CORPORATION**

GENERAL OFFICES • EVANSTON, ILLINOIS

# *A Pharmaceutical Triumph*

**In Vi terra, J. B. Roerig and Company offer you for the first time a more complete, balanced formula for the management of multi-vitamin deficiencies. Vi terra is the result of years of intensive research, together with months of pharmaceutical manufacturing research. Indicated wherever you would normally use multi-vitamins.**




**9 vitamins and 12 minerals } all in 1 capsule**

# in Multi-Vitamin Therapy

Multi-vitamins are not alone the complete answer to protective nutrition. More and more, the mineral elements are being recognized as "spark plugs"—playing an all-important, if still unmeasured part in building and restoring body health. The catalytic-synergistic action of the minerals with the vitamins makes the difference in speeding up enzymatic processes on which the body is dependent for its functions.

**Vi terra** contains all the vitamins known to be essential to human nutrition and, in addition, 12 minerals designed to act as catalysts in improved vitamin metabolism. Advance clinical reports indicate that when proper minerals are supplied with the necessary vitamins, the powerful activity of the enzymes present in the body is stimulated and increased.

With **Vi terra,** the physician or surgeon can anticipate more rapid and potent effects than can be obtained with less complete formulations.

## ALL IN ONE CAPSULE

| VITAMINS | | MINERALS | |
|---|---|---|---|
| Vitamin A *(Refined Fish Liver Oil)* | 5,000 USP Units | Cobalt *(Cobaltous Sulf. 7 $H_2O$)* | 0.1 mg. |
| Vitamin D *(Irradiated Ergosterol)* | 500 USP Units | Copper *(Cupric Sulfate)* | 1 mg. |
| Vitamin $B_1$ *(Thiamine Hydrochloride)* | 3 mg. | Boron *(Sodium Metaborate)* | 0.2 mg. |
| Vitamin $B_2$ *(Riboflavin)* | 3 mg. | Iron *(Ferrous Sulfate)* | 10 mg. |
| Vitamin $B_6$ *(Pyridoxine Hydrochloride)* | 0.5 mg. | Iodine *(Potassium Iodide)* | 0.15 mg. |
| Niacinamide | 15 mg. | Calcium *(DiCalcium Phosphate)* | 213 mg. |
| Vitamin C *(Ascorbic Acid)* | 50 mg. | Manganese *(Manganous Sulf.)* | 1 mg. |
| Calcium Pantothenate *(Dextro)* | 5 mg. | Magnesium *(Magnesium Sulf.)* | 6 mg. |
| Mixed Tocopherols Type IV | 5 mg. | Molybdenum *(Sodium Molybdate)* | 0.2 mg. |
| | | Phosphorus *(DiCalcium Phosphate)* | 165 mg. |
| | | Potassium *(Potassium Sulf.)* | 5 mg. |
| | | Zinc *(Zinc Sulfate)* | 1.2 mg. |

***DOSAGE:*** Due to the catalytic-synergistic action of certain minerals with vitamins in vivo, it is suggested that one **Vi terra** capsule a day will serve adequately for supplementary nutrition. For quicker results three or more **Vi terra** capsules daily may be prescribed. Supplied in bottles of 100 capsules. You are invited to send for a clinical trial supply.

# Vi terra

**For More Complete, Better-Balanced Multi-Vitamin Management**

**J. B. ROERIG AND COMPANY** · CHICAGO · WINDSOR, CANADA

interne and resident training. The institution has also been approved for specialty-board training in surgery, internal medicine, orthopedics, obstetrics, gynecology, roentgenology, and pathology.

¶ Dr. William J. Kerr, professor of medicine, University of California, avers that "the quality of service to the sick is of a very high order."

¶ Says Dr. Windsor C. Cutting, of the Stanford University Medical School: "My impression is that the type and quality of care are excellent."

Mr. Kaiser says, "When groups of prospective subscribers inquire about enrolling in the Permanente Plan, it is our practice to ask them to investigate all types of prepaid medical and hospital services, make comparisons, and choose the best plan available and most fitting their needs.

"I unequivocably believe in the American tradition of free enterprise," he concludes. "The Permanente Plan represents one development of private practice and free enterprise. I feel confident that the doctors can show that their segment of the private enterprise system is able to rise to the challenge."

## Osteopaths Honored by Government

Some 11,000 osteopaths recently swarmed into St. Louis for their diamond jubilee. Seventy-five years had passed since the profession

# *Only on your Rx . . .*


When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this **uterine tonic**, time-tested ERGOAPIOL (Smith) WITH SAVIN —only on your prescription—serves the best interests of physician and patient.

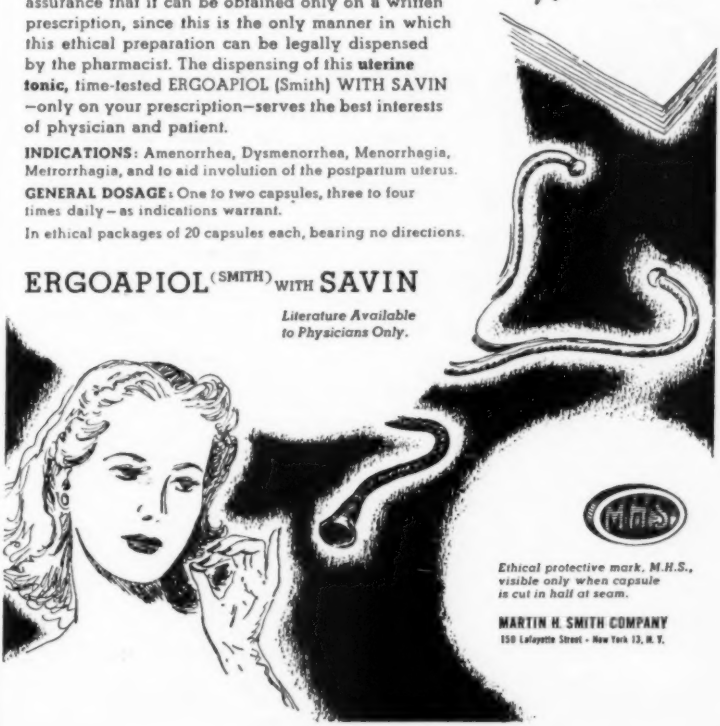
**INDICATIONS:** Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

**GENERAL DOSAGE:** One to two capsules, three to four times daily—as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

## ERGOAPIOL (SMITH) WITH SAVIN

*Literature Available to Physicians Only.*



M.H.S.

*Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.*

**MARTIN H. SMITH COMPANY**
150 Lafayette Street • New York 13, N. Y.

*and* **NOW**

in the Control of Edema

# ORAL

Mercurial Diuretic

*tablets* **MERCUHYDRIN**®

with Ascorbic Acid

One to two tablets daily will permit maintenance of patients at optimal or "dry" weight. *Tablets* MERCUHYDRIN *with Ascorbic Acid* combat the pathologic retention of water-binding sodium which imposes a mounting fluid burden on the failing heart. Effective and usually well-tolerated, they are of special value in treatment of ambulatory patients.

MERCUHYDRIN mobilizes water and sodium from inundated tissues and fosters their urinary excretion. Oral maintenance therapy . . . *Tablets* MERCUHYDRIN *with Ascorbic Acid* . . . supplements the parenteral mercurial and diminishes the number of injections required to maintain the edema-free state.

*Tablets* MERCUHYDRIN *with Ascorbic Acid:* Bottles of 100. Each tablet contains meralluride 60 mg. and ascorbic acid 100 mg.

*Lakeside Laboratories,* INC.

MILWAUKEE 1, WISCONSIN

was founded by Andrew Taylor Still. In honor of the occasion, the U.S. Post Office authorized use of a special cancellation stamp on mail issuing from St. Louis during the five-month period, March through July. The cancellation read, "Diamond Jubilee, Science of Osteopathy, St. Louis, Mo., 1949."

## Urges Laws To Ban Rebates

The Norfolk Medical News of Boston is beating the drums for action on the AMA recommendation that legislation against rebating be passed in states now lacking such laws. "Although we do not believe that fee-splitting and rebating are common in Massachusetts," it says, "we cannot suppose that our state, any more than the others, stands guiltless."

The News points out that it was recently suggested to the Massachusetts Medical Society's Committee on Legislation that a suitable measure be introduced. The state society demurred, complains the Norfolk group. Its reason: Such action at this time might lead to unfavorable publicity during a period which threatens to be crucial in respect to national health insurance.

"The House of Delegates," the News retorts, "was undoubtedly well aware of the national health insurance legislation pending in Washington when it passed the resolution for state laws against rebating. We feel sure that its recommendation was addressed to all state medical societies, including Massachusetts. It is difficult to see how the introduction of appropriate legislation could be interpreted as anything but cooperation with the AMA. It would certainly be far better to take the initiative in this matter than to wait, as was the case in

California, for a lay organization to bring it to public attention via the headlines."

## Labor Blamed for Health Insurance Fizzle

This year's campaign for compulsory health insurance flopped, says left-of-center columnist Albert Deutsch, mainly because it lacked grass-roots labor backing. "The myopic leaders of organized labor who paid lip service to national health insurance," he asserts, "have failed miserably in their duty to energize their millions of members into informed and active support of the system that would mean so much to them and their families.

"The AFL, CIO, and the railroad brotherhoods," says Deutsch "all endorsed the health insurance measure enthusiastically. But, in contrast to organized medicine, which raised at least $2 million for opposition propaganda, organized labor gave almost nothing from its impressive treasuries toward educational campaigns for the bill. Organized labor just laid down on its job."

Also on Deutsch's blacklist: The "lackadaisical Fair Dealers who, having unexpectedly managed to retain their jobs in Washington, were so delighted that they forgot about their program"; and "the flabby liberals who are long on proposing, short on following through." Whitaker and Baxter, he says, "probably will seek much of the

credit for checking the health insurance drive in Congress. They are indeed doing a slick job of press-agentry for the medical *status quo*."

Deutsch pins orchids on those he feels have worked hardest for compulsory health: Federal Security Administrator Oscar Ewing, "an eager and vigorous, if not always apt and knowing, crusader for national health insurance"; and the Committee for the Nation's Health, which has "fought hard under the constant handicap of insufficient funds and staff."

## British Bet on Getting Sick

Despite socialized medicine, the British still like to gamble on the state of their health. A new epidemic insurance policy issued by Lloyds of London pays off 1,000 to one. All the subscriber has to do to strike it rich is come down with smallpox, typhoid, or infantile paralysis.

## Social Aid Costs Going Up

The cost of equipping our citizens with a social security cushion has soared to nearly five times the pre-war figure, according to U.S. News & World Report. The annual tab for private and public social security is now more than $13 billion, the Washington magazine states. In 1939 the figure was about $3 billion; twenty years ago, approxi-

mately $1 billion. Plans to raise the ante in time of business set-back would put the bill next year at $17 billion, around one-fifth of the national income in 1940, considered a prosperous prewar year.

Contributors to the social aid program are:

*Private industry.* It's upping substantially the bill it pays to protect workers against life's hazards. In 1949, business concerns will pay out $1¼ billion for their welfare arrangements. Workmen's compensation will add another $568 million to this total.

*States, counties, and cities.* They are contributing $2.8 billion this year—about thirteen times what they put out in 1929.

*Federal social security.* This costs the most, is growing the fastest. Laws already on the books will result in an expenditure of $8½ billion in 1949—fifteen times the amount paid twenty years ago. Most of this outlay goes for unemployment compensation, veterans and old-age pensions.

Of these, unemployment compensation is the most expensive benefit, with about $2½ billions being paid out yearly.

## System for Arbitrating Doctor-Patient Disputes

The San Francisco Medical Society has assigned nine members the task of arbitrating disagreements between doctors and patients. Known as the Professional Conduct Committee, the trouble-shooting

M.D.'s serve a three-year term, fill a twofold purpose: (1) to protect the public from that minority of doctors who may overcharge; (2) to defend members against patients' ill-founded accusations, handle the trouble-makers and neurotics who harry even the best-intentioned physician.

When a patient phones the society with a grievance against a doctor, the caller is first urged to discuss the matter frankly with his physician. If this doesn't work, the patient is advised to submit his complaint in writing to the committee.

The latter then considers the case at one of its frequent meetings. An effort is made to reach a decision and notify the persons involved as quickly as possible. Letters to patients are first submitted to the society's legal counsel.

Typical reprimand to a physician: "The Committee wishes to inform you that they consider your fee grossly excessive and far above what should be charged a patient in these circumstances for the same or

## HANDITIPS

**▶ What nontechnical procedure or device have you found helpful in conducting your practice more efficiently? MEDICAL ECONOMICS will pay $5-$10 for original ideas worth passing on to your colleagues. Address Handitip Editor, Medical Economics, Rutherford, N.J.**

# Know Your ACES, Doctor

The importance of using the correct bandage in treating specific conditions is self-evident . . . important enough for B-D to provide two distinct ACE BANDAGES.

## ACE® COTTON (NO. 1)

***All Cotton Elastic***

Universally accepted, as the original cotton elastic bandage, in the management of varicose veins and ulcers, strains, sprains and various muscular injuries. Unique weave provides maximum elasticity without rubber.

## ACE® REINFORCED (NO. 8)

***Reinforced with Rubber***

Increasingly employed because its prolonged support is ideal for surgical use, where occlusive pressure bandaging is required . . . also for weak knees and ankles, muscle rupture, and as a general supportive bandage.

**ACE BANDAGES** *are cool, comfortable, long-lasting and washable.*

**Remember . . ."Only B-D makes ACE Elastic Bandages."**

**BECTON, DICKINSON & CO., RUTHERFORD, N. J.**

similar procedures. The committee therefore recommends that you make a substantial reduction in this figure."

To a patient: "Your complaint against Dr. G has been carefully reviewed and investigated. It is the unanimous conviction of the committee that you should be exceedingly grateful to the doctor for the splendid care given your wife in the case of this extreme emergency, which might well have taken her life. His charges for these services are most reasonable."

During the first half of 1949 only twelve complaints were filed against members of the society, whose active membership is approximately 1,300.

The sixty-seven cases considered in 1948 consisted of twenty-nine fee disputes, sixteen malpractice suits, six accusations of advertising or self-aggrandizement, twelve unethical-conduct suits, and four miscellaneous.

## Why M.D.'s Are So Busy

A Texas wit has a glib retort for patients who complain that their doctors are not always available when needed.

"Leading M.D.'s from coast to coast," he writes his local paper, "are busy testing cigarettes, soaps baby foods, and other products Their findings must then be tabulated and made ready for relay back to us over the radio, all of which takes time."

# * Index of Advertisers *


# Healing time is cut by half with

# Triple Sulfa Cream

TRADE MARK

In a recent study[1] of 200 consecutive cases of vaginal and cervical surgery treated post-operatively with Triple Sulfa Cream average healing time was actually reduced 50 per cent. In all instances speculum inspection disclosed "a clean granulating surface without a superficial membrane attached, and no apparent slough present," with resultant complete absence of malodorous vaginal discharge. Among 121 cases of cervical conization not a single instance of post-operative occlusion occurred.

Triple Sulfa Cream, compounded of three selected sulfonamides, each with its own pH range of maximal activity, exercises potent antibacterial action against all the common wound pathogens. By reducing wound infection to a minimum, Triple Sulfa Cream as a post-operative dressing, promotes sound structural healing, shortens hospitalization, and simplifies nursing care.

In many forms of vaginitis and cervicitis, also, Triple Sulfa Cream brings prompt relief of symptoms by virtue of its powerful bacteriostatic and bacteriocidal action at the actual site of invasion.

1. Marbach, A. H.: Am. J. Obst. & Gynec. 55: 511, 1948.

Triple Sulfa Cream is available in 3 ounce tubes, with or without the Ortho applicator.

ortho pharmaceutical corporation

Raritan, New Jersey